

# THE MODERN HOSPITAL

*A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services*

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## AN EARLY GREEK SANATORIUM AND DISPENSARY— CHIEF SEAT OF AESCULAPIAN WORSHIP

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ST. LOUIS, MO.

THE front cover of this issue of THE MODERN HOSPITAL shows a picture of the Chryselephantine figure of Æsculapius in the temple at Epidaurus, as restored after the researches of Defrasse and Lechat<sup>1</sup>, which were conducted under the auspices of the French Government.

In Argolis, situated at a distance of about six miles from the coast, are to be found the remains of what was once the most famous of the many Greek temples erected in honor of Æsculapius. The town of Epidaurus is located near the sea, but the large group of medical buildings was situated inland.

Æsculapius, or Asklepios, was first mentioned in the Homeric poems as a Thesalian king, not as a god; but divine honors were given to him in later times. Although medicine among the Homeric Greeks was quite distinct from religion, the worship of Æsculapius as the god of healing is worthy of notice.

Greek temples of medicine (called asclepia) were numerous, and in the work of Schulz<sup>2</sup> more than sixty of them are described. The temple at Epidaurus and that on the island of Cos were particularly famous. To these and to similar shrines sick persons were conveyed in order to be cured,

just as in modern days relief is sought by means of a devotional pilgrimage, or from the waters of a sacred spring. Then, as possibly is done now, relief was sometimes sought by deputy. The patient, or his representative, after ablution, prayer and sacrifice, was made to sleep upon the hide of the sacred animal, or at the base of a statue



Restoration of the façade of the temple of Æsculapius.

of the god, while sacred rites were performed. During the night the proper remedy was indicated in a dream. A record of the case—particularly if it were successful—was made on the columns or walls of the temple or on a votive tablet.

<sup>1</sup>Defrasse et Lechat: *Epidauré restauration & description des principaux monuments du sanctuaire d'Asclepios*. Paris, 1895.

<sup>2</sup>Schulz: *Historia Medicinæ*. Lipsia, 1728.

The worship of Æsculapius passed from the Greeks to the Romans and extended to all countries subjugated by the two nations. The Æsculapian temples were both hospitals and places of worship. None but the initiated could enter these shrines. Only the priests could look upon the columns of Hygeia at Ægeum; no dog was permitted to enter at Delphos; no child could be born at Epidaurus, and no one was allowed to die within its grounds.

It was in the valley of the Hieron (consecrated place) that a noted group of buildings existed in early days. In these the worship of Æsculapius was carried on for a long period.

Richard Caton<sup>3</sup> has given us his idea of an outline restoration of the buildings—a plan which does not profess to be accurate. The difficulties attending the identification of the various structures were mentioned by Valentine Mott.<sup>4</sup> He said: "We found in several places confused heaps of ruins, which, however, were not sufficiently defined for one to say positively to what character of edifice they belonged, or whether they were a part of the temple or of the ancient city of Epidaurus." The Hieron group included the Propylæa, or ceremonial gateway; a large quadrangle about 250 feet square; the temple of Æsculapius, or central shrine; the Abaton; the Tholos, etc.

#### Statue—Work of Thasymedus

In the temple of Æsculapius was a statue of colossal size, the handiwork of Thasymedus, made of gold and ivory, which represented the god of medicine as an old man seated on a throne, holding a staff in one hand and resting the other on the head of an enormous serpent. A dog, the emblem of vigilance, lay reposing at his feet. The

whole figure bore a striking resemblance to that of Zeus.

The theater is said to have been built about the year 450 B. C. by Polycleitus, architect of the Tholos. Pausanias states that it was the most interesting of all the theaters existing in his time; and Mott<sup>4</sup> says: "This immense theater, incredible as it may seem, would accommodate within its enclosure, I should imagine, at least 30,000 persons." Caton<sup>3</sup> tells us that "the acoustics of the theater are perfect; a sound little louder than a whisper uttered on the stage can be heard in every part."

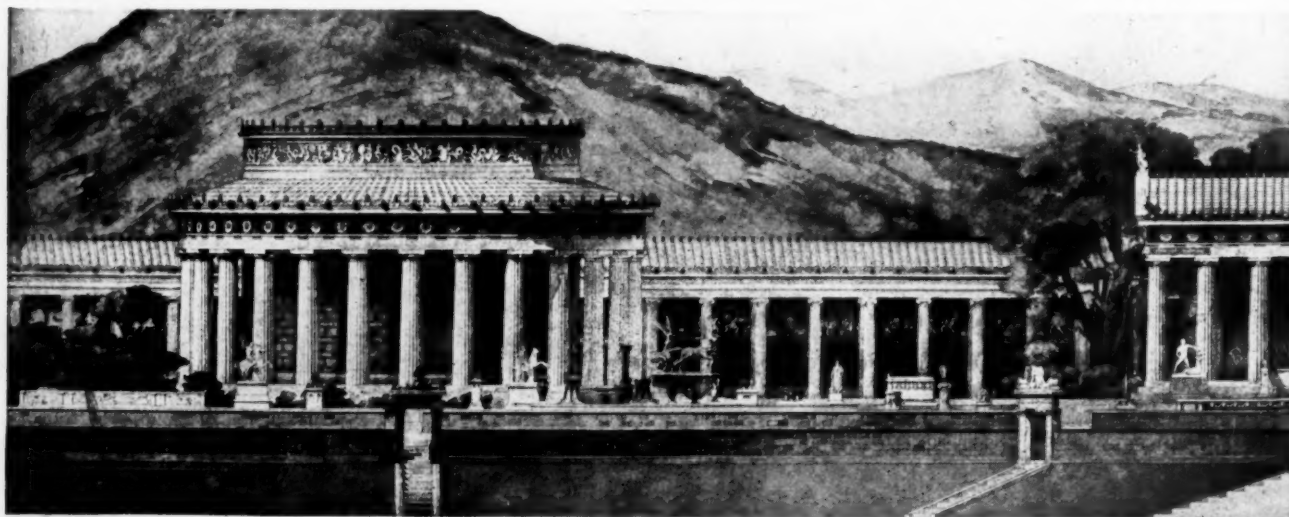
In the picture at the bottom of this and the following page, the Tholos is seen at the left, the temple of Æsculapius in the center, and behind both the Abaton, a long portico, open on the side shown in the picture, and walled on the other.

The Tholos is declared to be the most beautiful circular temple ever built by the Greeks; it was built by Polycleitus the Younger, and took twenty-one years to build. One theory holds that the Tholos was a drinking fountain, where rose a healing spring; another theory is that it was used for minor sacrifices. Below it is a labyrinth, which may at one time either have been a cistern or the home of the sacred serpents.

The temple of Æsculapius was the central shrine, and was richly decorated and colored. The Abaton constituted the main ward for the sick, and was furnished with pallets, lamps, tables, altars, etc. It contained room for about 120 beds, and it is believed that the open-air features of the Abaton may have been a great factor in such cures as were effected. Other buildings about the grounds, not shown in this picture, are thought to have been used to house patients, and the total capacity of the Hieron is estimated to have been some five or six hundred patients.

<sup>3</sup>Caton: *The Temples and Ritual of Asklepios*. Hertford, 1899.

<sup>4</sup>Mott: *Travels in Europe and the East*. N. Y., 1842.



The Tholos.



In front of the buildings shown in the picture below is seen something resembling a sunken pit. This is the Stadium, which seated 12,000 to 14,000 spectators. The presence of a stadium in connection with a hospital is strange to modern ideas; but in the Greek mind athletics and health were doubtless closely associated. It is probable that multitudes of athletes and Greeks who merely wanted a holiday came to the Megala Asklepia just as they did to the Isthmian or Olympic games.

The technic followed by Æsculapius and his disciples is largely a matter of conjecture. It is known, however, that the large yellow snakes, with which the valley abounded, were held sacred, and were supposed to exercise a healing power by licking with their tongues any affected part of an invalid. The snakes were harmless and quite tame, and the sick were in the habit of feeding them with cakes. The dog, as well as the snake, was sacred to Æsculapius, and dogs in the temple were trained to lick any ailing part of the patient.

Miraculous cures were claimed for all sorts of diseases, and history shows that the Greeks were not a whit behind the ignorant of modern times in gullibility. One inscription tells us that the god cured dropsy by the method of cutting off the afflicted person's head, holding him upside down till the fluid drained off, and then replacing the head. Blindness and paralysis were often cured by the licking action of dogs and serpents.

In later times, however, we find many common-sense practices carried out. Dieting, hot and cold baths, poulticing, massage, counter irritation, and light exercise were frequently prescribed. The pharmacopeia was limited, and included such things as hemlock juice, hellebore, squills, and lime water.

The Hieron and its environments exercised, however, such therapeutic effect as there may be in beauty. Nothing was spared to make the build-

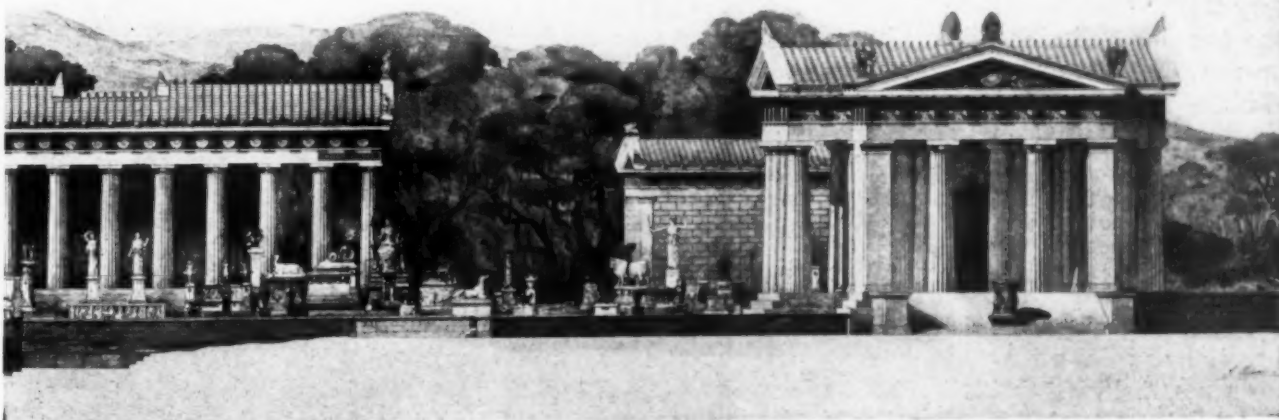
ings magnificent monuments. Marvelous sculpture, scores of statuary figures, busts, groups, colored bas-reliefs, pediments, shrines, decorative vases and fountains, doors of ivory inlaid with gold—such things must have impressed the sick with the power of the god. Large and lofty trees formed groves, low mountains made a view wherever one turned, and soft breezes and the pure mountain air undoubtedly had a part in many recoveries. A library furnished occupation for the scholarly, and music, religious dances and festivals made the time pass pleasantly, and probably induced a hopeful and beneficial condition of mind which aided recovery.

#### FACILITIES AVAILABLE TO VETERANS' BUREAU HOSPITALS

The U. S. Veterans' Bureau is now operating forty-five hospitals with a bed capacity of 16,359, of which number 11,802 are occupied, according to the annual report for 1923. Fifteen hospitals operated under the U. S. Public Health Service are also for use by the Veterans' Bureau, and make available 388 beds. The War Department has placed 3,018 beds in its hospitals at the disposal of the bureau, and the Navy Department, 679 beds. The ten branches of the National Home for Disabled Volunteer Soldiers have set aside 3,659 beds, and there are 900 beds at St. Elizabeth's Hospital, Washington, D. C., occupied by disabled ex-service men. In contract hospitals throughout the country there are 4,934 patients which represents 21.7 per cent of the total number of patients hospitalized. With the development of the new hospital facilities the contract load has decreased since March, 1923, when there were 7,379 patients in contract hospitals.

#### NEAR EAST RELIEF SURVEY FOR 1923

During the year 1923 thirty-three hospitals and sixty-one clinics of the Near East Relief were operated with an average of 395,427 treatments per month. This work is supervised by eight American doctors, twenty-one American nurses, fifty-two local doctors and 121 local nurses.



Temple of Æsculapius.

The temple of Artemis.

## THE RELATIONSHIP OF HOSPITAL DEPARTMENTS TO THE HOSPITAL LABORATORY

By HENRIETTA A. CALHOUN, M.D., DIRECTOR, ROCKFORD HOSPITAL LABORATORY, ROCKFORD, ILL.

THE relationship between the laboratory and the other departments of the hospital presents many opportunities for friction. The laboratory, in the very nature of its organization, must stand as a more or less independent unit responsible to (1) the nurses' training school for teaching nurses laboratory procedures, and for laboratory examinations required for the personnel; (2) the individual physicians for ethical treatment of their patients and their records; (3) the staff collectively for interpretation of results of laboratory findings, for consultation and advice and for prompt and constant service; (4) the superintendent for efficient in-patient service and for the adjustment of interdepartmental relationships; (5) the board of trustees for maintenance of a high standard and for the growth of the laboratory and for the extra-departmental policies, and relationships with outside institutions and organizations.

In our laboratory we have felt that a few fundamental principles and a minimum of rules work best.

### Relation to Nurse Training School

For the nurse training school we offer didactic courses in bacteriology and individual laboratory training. The preliminary course in bacteriology, which is taught by the supervisor of the training school, is followed in the first year by a demonstration and lecture course by the laboratory director together with a demonstration course in urine analysis. The amount of actual laboratory work, of course, depends on the size of the class. With a class of sixteen or eighteen it is impossible, unless the work is done in sections, to give laboratory training unless a special room is set aside in the training school, while with a class of three or four the group may be taken direct to the clinical laboratory and given practical work. In the last year of training, each nurse spends a period of four hours per day for four weeks in the laboratory doing urinalyses, blood counts, throat cultures, and helping with all the routine work under direct supervision. This gives us personal contact with the best trained nurses, prepares them for giving efficient service as clinic, hospital, or office nurses and, in a few cases, opens up a new field which invites the further pursuit of laboratory work. They realize the limitations

and the possibilities of laboratory work and know how to take specimens intelligently. We are not aiming in any way to turn out trained technicians, nor do we believe that all nurses should become laboratory workers. It has been interesting to notice the reaction on the part of the nurses. They like the work and, because of their practical work, have no trouble with the laboratory part of their state board examinations. We have had come to the hospital two graduate nurses offering voluntary service in exchange for training. We have made it customary to have the nurses' laboratory service include no cleaning or dusting aside from that of helping to clean laboratory apparatus and glassware. But they must learn how to get glassware chemically clean and how to care for balances, centrifuges, microscopes and colorimeters.

### Rotating Service Plan Used

This year we are initiating a new plan of rotating service to make the nurses' assistance of greater value to the laboratory, in order to tide over the gaps of having an interval period when the nurse beginning training is not helpful. By the new arrangement a nurse enters in the morning for two weeks, then transfers to afternoon service for the last two weeks at the same time that a nurse enters the morning service. In this way the nurse on afternoon service is always familiar with laboratory routine.

In the case of the individual physician, the records of findings are not open to the general public or to other members of the profession without his authorization. No records are given to the patients direct except on personal order from the physician.

*The laboratory director should be a member of the hospital staff.* Until one has worked without such relationship it is hard to realize its importance. The Rockford Hospital has a rule to the effect that a physician is not eligible to staff appointment until he has resided in Rockford for one year. Thus during the first year the director is expected to attend monthly staff meetings as a guest. That limits decidedly the freedom in discussion and the desire to bring up new policies. The most valuable service the laboratory could render should be that of a consultant. The director of the laboratory should know the cases in the hospital so as to be able intelligently



<div> <div>Rockford Hospital</div> <div>Rockford, Illinois</div> <div>Schedule of Laboratory Fees and X-Ray Charges</div> </div>		<b>Schedule of Laboratory Fees</b> All Laboratory Examinations for Patients in the Hospital are made <u>WITHOUT CHARGE</u> .	<b>X-Ray Charges</b> For patients in hospital
<b>Bacteriology:</b> Throat cultures and slides for diphtheria ..... \$1.00 T. B. slides ..... 2.00 Cultures for isolation of organisms ..... 3.00 Vaccines ..... 5.00 Animal inoculation ..... 5.00 to 10.00		<b>Blood:</b> Complete with differential ..... \$5.00 Red and white count and hemoglobin ..... 3.00 Leucocyte count ..... 2.00 Differential alone ..... 3.00 Malaria parasites ..... 3.00 Coagulation time ..... 1.00	\$3.00      \$5.00      \$7.50 Foot      Knee      Bladder Ankle      Chest (Flat)      Hip Finger      Clavical      Sacro Iliac Hand      Shoulder      Spine (lateral) Wrist      Spine (6 vertebrae) Elbow      Skull Dental (complete)
<b>Serology:</b> Langes colloidal gold ..... 5.00 Wassermann test ..... 5.00 Widal test—single organism ..... 2.00 " " "triple agglutination ..... 5.00 Blood grouping, per person ..... 5.00		<b>Urine:</b> Qualitative—routine, albumen, sugar, acetone, diacetic, indican and sediment ..... 2.00 Dase reaction ..... 2.00	Kidney ..... \$3.00 to 10.00 Stomach (6 hr. plates) ..... 10.00 Stomach, series ..... 15.00 Fluoroscope ..... 5.00 All stereoscopic, extra ..... 3.00
<b>Chemistry:</b> <b>URINE:</b> Quantitative ..... 2.00 Phthalein excretion ..... 5.00 <b>BLOOD:</b> Quantitative sugar, nitrogen, creatinin, creatin and urea, each constituent ..... 5.00 <b>MILK:</b> Analysis ..... 3.00		<b>Gastric Contents:</b> Routine ..... 5.00 Fractional ..... 5.00 to 10.00 <b>Feces:</b> Routine—complete ..... 5.00 Occult blood ..... 2.00 Parasites and ova ..... 3.00 <b>Transudates and Exudates:</b> ..... 3.00 <b>Tissue:</b> Pathologic examination of tissue ..... 5.00	
		Tissue to be sent for microscopic diagnosis should be placed in 10% formalin solution for mailing.	

Four-page folder of Rockford Hospital's schedule of laboratory fees.

to advise laboratory procedures to be done and to interpret intelligently the results to the physician in charge.

Our system of free laboratory service has already been explained. Under this system there is no limit to the work the physician may order, and there is no charge for the advice of the laboratory director. This service is not limited to the staff but is extended to all physicians eligible to practice in our hospital, which is an open hospital.

We have not yet found it necessary to limit our time of doing things. For example, urine specimens routinely come down on admission and the morning following. In general, these specimens are received early in the morning, but examinations will be made any time through the day. We never discourage any laboratory orders, even though we may at times question the value of them, because we want our laboratory to be used freely. If a doctor has the idea that he wants a urea on the urine of a patient whose diet is not regulated, we do it following our report with our conception of the limitations of the value of the procedure, and a suggestion for checking with a blood urea or a determination of the McLean's formula.

We always arrange for some one to be available for night emergency calls. These are few in number, but always important, as they are almost always questions of life or death. We do not permit physicians to do their own laboratory work in the hospital, and we are able to enforce this because we are always ready to give the service desired.

We believe that the biggest factors in preventing friction between the laboratory and the staff are the three fundamental principles:

(1) That the laboratory director shall be a

full-time employee, a graduate physician who has no outside practice.

(2) That our cases must be referred to the laboratory by a physician and no work done direct for patients, all of the examinations being made on the attending physician's order and reported direct to him.

(3) That the laboratory does no treatment work.

Each year the president of the staff appoints a laboratory committee, usually composed of three members whose duty it is to help formulate policies the staff desires to have carried out and to whom mooted questions may be referred by the director, or by the staff. It is really an arbitration tribunal and an advisory board. Questions such as the occurrence of several cases of staphylococcus infections in the nursery, or the sudden need of an unusual number of throat cultures are reported to the committee. A request for single Widal test arouses no suspicion of an epidemic situation but when five separate Widal tests are requested by five different doctors within two days we are ready to cope with a possible typhoid outbreak. In this way we can act as a clearing house for unusual epidemic conditions and are able to protect our hospital. Questions of ethics and problems that are purely medical are referred to the staff as a whole for discussion and determination of the course to be pursued.

### Responsibility of Floor Nurse

The interdepartmental relationships are easy after they are once established. The closest relationship is that with the floor nurses. They are responsible for getting the specimens to the laboratory and for the carrying out of a few standing orders. All specimens are sent with a stand-



ard order slip as follows. These order slips are mimeographed in the hospital, with spaces for orders.

#### LABORATORY ORDER

Room No. 320. Dr. Erasmus

Patient Mary Parlapiano

Order Urine analysis

Urine voided 5vii @ 6 A. M.

Date 10-4-23

Clean containers for the specimens are kept in an easily accessible unlocked cupboard. When the laboratory is closed specimens are returned to this cupboard. After examination the records are made out in standardized sheets and filed in the patient's chart, duplicate records being kept in the laboratory.

The standing orders are:

(1) In all cases an admission urine specimen; in operative cases a post-operative specimen; in maternity cases a specimen on the fifth and tenth days postpartum.

(2) Coagulation time on tonsil cases.

(3) Throat cultures on all patients complaining of sore throats.

(4) Eye smears or vaginal smears on all babies showing discharges from eyes or vagina.

(5) Blood specimen for a Wassermann test from umbilical cord in all obstetrical cases.

(6) All tissue removed in operating room sent to laboratory.

All other laboratory work is on order, that is, written by the physician in the order books on the floors and transmitted to the laboratory by the floor nurse or by the special nurse in charge of the case.

#### Cooperation with Dietary Department

Diets are routinely in charge of the dietary department, but special diets for diabetics become laboratory procedures. We have found that the easiest way for us to handle these interdepartmental diets is to express the diet in terms of grams and leave the translation into salad, vegetables, eggs and meat with the dietitian. In this way we are not ordering spinach for a special diet on a day when lettuce and tomatoes are being served on a general diet. The slip goes down to the diet kitchen as:

JOHN SMITH. Diabetic. Weight 135 lbs.

Basis of 1.0 grams protein per kilo.

Glucose tolerance 90

Optimal daily diet

Protein: 63 grams

Fat: 118 grams

Carbohydrate 42 grams

No sugar; use saccharine.

May have tea or coffee.

Problems such as the bacterial content of milk, the presence of preservatives in food, may be referred to the laboratory.

#### The Superintendent's Relation

Laboratory charges are credited to the laboratory and laboratory orders are all handled through the office with the O. K. of the superintendent. The charges are the same as for that of out-patient work. The orders for equipment—that is, replacement such as chemical and ordinary glassware go through without any question. The orders for new apparatus require special action. It is perhaps significant that the initiative for new purchases has come from the superintendent. We plan and wonder when we can have a new microscope or a still, or an electric embedding plate, and one day the superintendent says, "I think we can have some extra equipment in September. Put your order on my desk." Thus the laboratory grows. In the past two years no order sent in has been changed, cut, or vetoed. A fixed flat salary for the director eliminates little friction points, but this salary should be commensurate with ability and service rendered and should be on "an upward sliding" scale.

The board of trustees has no special laboratory committee. All questions of policy, all problems for advertisement and growth of the laboratory and the addition of special apparatus come within their province. These matters are referred to the president of the board of trustees, for reference to the executive committee which is composed of the chairman of the various standing committees.

Perhaps it will be easiest to give concrete examples of the matters that have been referred during the past year. Our laboratory became very cramped for help and for room. The problem of the amount of service we might have and the salaries we were able to pay was decided by the board of trustees. There was an extra room made available for laboratory use, and the entire department space was painted and put into repairs.

#### Funds Needed for Research Work

At present our problem is the raising of funds for research work. We have outlined the problems of greatest interest to the laboratory and to the staff—definite problems which we feel must be solved, and some time within the next year we feel that we shall work out a plan for financing the research department, without in any way tak-

ing from the gifts that may come to the hospital. We feel that the laboratory must not grow at the expense of any other part of the hospital and that it must not divert funds which should go to the hospital as a whole.

Advertising for the laboratory is limited to the sending of letters to physicians of our own town and of the surrounding counties. Last year, we sent a mimeographed letter explaining our three fundamental principles and enclosed our card of charges for out-patient work. A few months later this was followed by a second letter adding protein sensitization tests to our list. Our returns from these letters more than cleared the overhead, but the method is not so satisfactory in our hands as the personal contact with physicians. One good loyal friend and advocate in a neighboring town is more valuable than all the letters we have sent. Perhaps the hospital would not hold such rigid views on the mooted question of the ethics of advertising the clinical laboratory, if it were dependent on out-patient work for a portion of its support. The decision of the board of trustees on opening the laboratory was that the support should be from the in-patient service, outside work being done at the price standards fixed by the other laboratories in the city.

We are claiming no new ideas, no originality in the working out of our plans and of our organization. It is a simple, easy, smooth running mechanism dependent upon close coordination of all its component parts.

#### A PLEA FOR MINIMUM QUALIFICATIONS FOR MAJOR SURGERY

Our expanding knowledge of disease has brought the demand for better service to the afflicted. The proper treatment for many conditions, particularly those of surgery, can be successfully supplied, only in hospitals where extensive equipment can be maintained. Disease in any form is in the nature of disaster and disorganizes the home. The people have learned the advantage of this service and the hospitals in Ohio have increased from 100 in 1890 to 300 today and the increase in number of beds is much greater in proportion. The patients are no longer satisfied with the service which hospitals formerly offered. Recognizing the needs of better service and more uniformity of standards, a few years ago, the American Medical Association organized a Council on Medical Education and Hospitals, looking toward better laboratories and equipment, better service, and better training for interns and nurses. Our association has a standing committee cooperating with this council and is also in cooperation with a like committee from the state hospital association, studying these problems.

Many vexatious problems have arisen in connection with hospital staffs which have attracted serious attention of this committee. Some hospitals have a closed staff of but a few physicians to whom all patients, on entering, are referred. Others have an open staff and any licensed physician may admit and treat patients. Both have

arguments in their favor. Your officers have been reminded on many occasions of the disturbing factors associated with the selection and operation of hospital staffs and their relation to medical organization. The intimate right of every individual to select his physician should be respected. It is only when he becomes a ward of the state, that he forfeits this privilege. The ethical relations between patient, physician and staff, offer a complex problem for solution. It is sincerely hoped that this joint committee can work out some tangible policy for a working staff for the average hospital. We advise that this committee be continued.

The movement for better hospital service has stimulated a growing tendency toward specialization. A surgeon undertaking a major operation assumes a grave responsibility to his patient whose life or death depends on its successful performance. A graduate should serve an apprenticeship as general practitioner of say five years before taking up a specialty. The diploma of the standard medical schools of this country, upon which all licensure laws are based, places no limitation to the range of practice in conferring the degree of doctor of medicine. Legal technicalities affecting reciprocity would arise in any attempt to amend our present laws, so as to require special qualification before engaging in a specialty. Hospital authorities have the right, however, to say who may be elected to staff appointments and it seems practical that such a basis of understanding can be worked out between this association through its surgical section, and the state hospital association, which would meet the approval of hospital authorities in requiring definite minimum qualifications before they be permitted to do major surgery in their hospital. While hospital standardization is being worked out, the time is propitious for such undertaking. This matter might appropriately be referred to our joint committee with the two associations.—*The Ohio State Medical Journal*.

#### PENNSYLVANIA PUBLISHES DIRECTORY OF STATE INSTITUTIONS

The Pennsylvania Department of Welfare has recently published a directory of state and semi-state institutions. This handbook supplements the map of state institutions which was recently prepared and issued by the Public Charities Association of Pennsylvania. It gives the names, location, capacity and districts of the state institutions and discusses briefly the methods and requirements for admission, discharge and parole. It contains in concise form data of interest to workers with mentally ill, mentally defective, epileptic, delinquent and other classes of patients and indicates sources of further information. The handbook may be obtained without charge from the Welfare Information Bureau of the Public Charities Association of Pennsylvania, Philadelphia.

#### DR. HAYNES TO DIRECT UNIVERSITY HOSPITAL, ANN ARBOR MICH.

Dr. H. A. Haynes, medical superintendent, Michigan Home and Training School, Lapeer, has been appointed medical director of the University Hospital, Ann Arbor, succeeding Dr. Christopher G. Parnall, Rochester General Hospital, Rochester, N. Y.

Dr. Haynes is a graduate of the University of Michigan medical college and served an internship in the university hospital from 1902-1903. From 1903 to 1907 he was physician at the Michigan Reformatory, Ionia. Since 1907 he has been at the Michigan Home and Training School.



# HOSPITALS AS A FACTOR IN THE MEDICAL PROGRAM FOR NATIONAL DEFENSE

BY MAJOR GENERAL MERRITTE W. IRELAND, M.D., SURGEON GENERAL, U. S. ARMY, WASHINGTON, D. C.,

THE meaning of the modern hospital to the community has come to be well recognized. It is now generally conceded to be a power for civil advancement beyond its function as a healer of the individual. The local industries speed on more certainly with the life-saving facilities of the hospital at hand to sustain the workers in their dangerous duties. The family also is reared with greater confidence in having the pediatric clinic and the expert accoucheur so readily accessible. The community indeed as a whole shares this confidence in the availability of scientific skill and equipment for the general welfare that makes for contentment and progress. The modern hospital, therefore, is doing its large service not only in caring for the people in the hour of distress but in pervading the community with an assured sense of physical protection. It is a form of emergency insurance that an exacting public requires and enjoys in every community.

There are times, however, when physical danger also faces the people as a nation. This is notably the case in war and our citizens are coming to realize that all security is fictitious that does not take account of this wholly possible accident of such far-reaching consequences. The immobile facilities in the community are seen to be of little consolation to the men who must leave their communities in defense of the nation. The propriety of having a representation of the local hospital talent prepared to leave with them will at once be apparent. And since the hospital problem in war is far different from that in civil life, being as much a problem of evacuation as of professional care, it will also be apparent that these hospital nuclei should be specially gotten together in advance and kept in a potential state of organization under military jurisdiction.

The National Defense Act as laid down by Congress has given the signal for building the framework of the necessary units for war and the Surgeon General of the Army has been charged with the organization and coordination of the required hospital units. The reasonable magnitude of a defensive action on the part of the nation, carefully worked out upon a consideration of our border requirements and outside possessions, has determined the scale of the war department plans.

This estimation, providing for six field armies,

has the quota of hospitals figured out on a basis of war requirements. There will be required for this project a vast number of general, evacuation and surgical hospitals and the various communities throughout the country are being called upon to organize these units at their local hospitals. It is the intention at present to organize these units only to the extent of their commissioned staffs, each staff consisting of a body of reserve officers within the staff of the civil institution who

will be prepared to branch off as the nucleus of a military hospital in case of war. These officers in time of peace are assigned to the positions they would fill in the military unit upon the outbreak of war.

## Staff Personnel Needed

The civil hospital arranging to sponsor a unit is first confronted with the question of selecting the appropriate type of unit for organization. This will depend largely upon a consideration of the number of officers that could be made available and also upon a consideration of their professional specialties and war-time experience. The commissioned staff of a surgical hospital consists of a commanding officer, a surgical chief assisted by an operating surgeon, eight assistant operating

## Hospital Preparedness

OUR program of national defense has necessitated the establishment of a system of military reserve hospitals throughout the country.

The National Defense Act has been the signal for building the framework of some 170 hospitals to serve as reserve units of general, evacuation, and surgical hospitals in connection with local hospitals of various communities.

The organization of the required number of these units has been carefully worked out by the Surgeon General of the Army upon a consideration of our border requirements and outside possessions. The war department plans call for a quota of hospitals to provide for six field armies figured out on a war-time basis.



surgeons, a medical chief with one assistant and a roentgenologist. There are also the following members who are not physicians: A dental surgeon, an evacuation officer, a registrar, a supply officer and a chaplain. The surgical hospital corresponds to the former mobile hospital. Its purpose in war is to bring the facilities for expert surgical aid as near to the battle line as possible so that the seriously wounded may not be jeopardized in their chances for recovery by immediate transportation to the more stationary hospitals in the rear.

The evacuation hospital is the most important center for the reception, care and distribution of war casualties. It receives its cases from the hospital companies of the medical regiments and from the surgical hospitals. A large amount of emergency surgery is done at the evacuation hospital and also a considerable amount of definitive surgery when the flow of patients is not too great. The following physicians are required on its staff: A commanding officer, an executive officer, a chief of surgical service under whom are four assistant chiefs and eleven surgical ward officers, a chief of medical service with two assistant chiefs and five medical ward officers, an evacuation officer, two roentgenologists and a laboratory officer. There are also the following non-medical members: Two dental surgeons, an adjutant, a detachment commander, a registrar, a quartermaster, a mess officer and a chaplain.

The general hospital which replaces the base hospital of the World War is a fixed establishment intended for definitive treatment. It requires on its staff a commanding officer, an executive officer, a chief of medical service with two assistant chiefs and seven medical ward officers, a chief of surgical service with three assistant chiefs and eight surgical ward officers, a chief of laboratory service with a laboratory officer, a roentgenologist and a receiving officer. The following non-medical members are also required: A chief of dental service and three dental surgeons, an adjutant, a registrar, a commander of the detachment of patients, a quartermaster with two assistant quartermasters, a mess officer and a chaplain.

#### Organization of Unit Staff

The organization of the unit staff in each case is undertaken by a representative staff member with the necessary military and administrative capacity whom the local hospital designates as its representative to command the unit. It is usual for the commanding officer to select as many members as possible from the staff of the institution so as to make it a representative organiza-

tion. It may become necessary, however, especially in filling the junior positions, to draw upon local physicians not holding places on the staff of the institution. The commissioned staff will thus remain representative of the community and in case of final organization for war it is expected that the enlisted personnel for the unit would also be recruited from the locality of the parent hospital. The nurses and enlisted members, however, are not to be assigned at the present stage of organization for the national defense.

No unit is authorized except upon the full agreement of the governing body of the civil hospital that is to foster it. Upon being authorized, the unit is given the name of the parent hospital and will, therefore, carry the traditions and local distinction of the institution in time of war. The hospital, however, contributes no money, beds, floor space or any other material aid since the necessary equipment and housing would be furnished by the army upon the outbreak of hostilities.

The hospital is said to sponsor the unit and the commanding officer whom the governing body selects is expected to safeguard the interests of the institution in forming his staff. The present plan of organization in fact is largely a step to protect the institution from the haphazard losses its staff would sustain in the rush of an emergency mobilization. In any national conflict a part of the staff of every civil hospital would be withdrawn for war duty but it is felt that the serious crippling of certain hospitals experienced during the past war can be wholly prevented if the proper adjustments are made with the cooperation of the institution before an emergency arises.

#### Staff Enrolled as Reserve Officers

The selected representative of the institution upon being commissioned and assigned becomes commanding officer of the unit and an agent of the war department. It becomes his responsibility to gather an adequate staff of professional men and in the name of the institution to maintain this staff in a reasonably well-organized state of preparedness for the exigencies of a national emergency. The staff members joining the unit are enrolled as reserve officers. Under this status they become available for duty in time of a national crisis but they have no compulsory training or any other infringement upon their daily routine in time of peace.

It is worthy of note also that the members of hospital units have a distinct advantage in receiving their war assignments in time of peace. When thousands of officers must be gath-

ered together and fitted into vacant places in organizations upon short notice there can be very small consideration given to individual qualifications and preferences since the essential positions must be filled as officers become available. When an effort is made, however, to determine individual adaptations beforehand and the correct assignment of officers is intrusted to a representative body in the community where their specialties and preferences are best known, it is believed that a long step has been taken in the interest of the individual as well as the government.

Hospital units are not subject to call in riots or other sectional disturbances. They can only be called out during the existence of a state of national emergency and this state of emergency must be pronounced by a decision of Congress before the President can order the units to mobilize.

Many representative hospitals and also medical schools have already adopted hospital units on the basis above outlined. The institution in each case has proceeded in the following manner: (1) The assembled governing body decides that the institution shall be represented as a reserve hospital unit in the National Defense program; (2) The most appropriate type of hospital unit is decided upon if there is any preference; (3) The authorities thereupon choose the logical staff member, one with the necessary military and administrative capacity, to represent the institution in the undertaking. Upon receiving this information the Surgeon General authorizes the unit requested and takes up with the commanding officer the matter of his enrollment and all further business pertaining to the organization. There is now ready for issue to each institution sponsoring a unit an engraved sheepskin recognizing officially the role which the institution is assuming in the National Defense program.

Although the various representative institutions throughout the country have come forth splendidly in the support of this project there are still many general, evacuation and surgical hospital units to be organized in order to satisfy the medical requirements of the six field army basis of preparation. It is hoped, therefore, that every qualified institution will eventually accept its part in this national project.

#### VETERANS' BUREAU MEDICAL AND HOSPITAL COUNCIL MEETS

The creation of a medical corps within the U. S. Veterans' Bureau, through an act of congress, was recommended to Director Frank T. Hines by the medical council in session at the Veterans' Bureau, Washington, D. C., July 24. This step was taken because of a belief that a permanent qualified personnel is highly es-

sential to the best operation of the bureau. The formation of a medical corps would give security of position to the doctors and assurance of permanent personnel to the bureau.

The doctors in attendance at the council sessions declared it their belief that the officials of the bureau could greatly improve the medical service through the establishment of post-graduate courses for the training of the personnel along the lines of their special duties. Such courses would be established in hospital management, rating, tuberculosis, neuro-psychiatry, x-ray, rhinology and diagnosis.

The committee recommended that the government hospitals at New Haven and Denver be re-established as schools for training of doctors in tuberculosis. The immediate establishment of diagnostic beds where the troublesome cases coming before the bureau might be properly observed by the qualified and trained diagnosticians, was also recommended. Such an arrangement would prove most valuable in cases where there was a difference of medical opinion as to the claimant's disability or doubt as to the exact diagnosis.

"We recommend the establishing of regional diagnostic groups, consisting of the best available bureau and local medical personnel and utilizing, so far as possible, as consultants, members of this council," said the members.

The council adopted a resolution recommending the creation of a unit under the direction of the medical director which would provide in permanent form a record of the new and valuable medical experiences resulting from the operation of such a large welfare organization as that of the Veterans' Bureau.

The establishment of a follow-up service was urged.

The names of Dr. Horatio Pollock, Albany, N. Y., expert in neuro-psychiatry, and Dr. Lawrason Brown, Saranac Lake, N. Y., a tuberculosis specialist, were added to the membership of the council. Dr. Kennon Dunham acted as chairman of the council and Dr. M. T. MacEachern, as secretary. Dr. Ray L. Wilbur, Stanford University, is the permanent chairman.

The committee on hospitals, dispensaries, and general medical welfare consists of:

Chairman, R. U. Patterson, Surgeon General's Office, U. S. A., Washington, D. C.; Louis H. Burlingham, Barnes Hospital, St. Louis, Mo.; Winford H. Smith, Johns Hopkins Hospital, Baltimore, Md.; S. S. Goldwater, Mt. Sinai Hospital, 5th Ave. and 100th St., New York, N. Y.; M. T. MacEachern, President American Hospital Association, Chicago, Ill.; W. C. Rappleye, New Haven Hospital, New Haven, Conn.; M. M. Davis, Jr., 17 W. 43d St., New York, N. Y.; Louis I. Dublin, 1 Madison Ave., New York, N. Y.

#### OFFERS EVENING COURSE IN HOSPITAL AND INSTITUTIONAL MANAGEMENT

The summer course in hospital and institutional management which has just closed at Temple University, Philadelphia, Pa., was a successful undertaking, according to Mr. Charles S. Pitcher, superintendent, Presbyterian Hospital, Philadelphia, in charge of the administrative lectures and instruction.

The success of the summer course has led to the establishment of a special evening course on the same subject beginning Tuesday evening, September 30. The sessions are from 7:30 to 9:30 and the course will continue for thirty sessions. Pamphlets containing information about the course may be obtained from Temple University.



## HOW GRAND RAPIDS HOSPITALS COLLECT DEBTS BY SOCIAL SERVICE METHODS

BY EDITH M. DYKEMA, EXECUTIVE SECRETARY, HOSPITAL COUNCIL OF GRAND RAPIDS, GRAND RAPIDS, MICH.

THE Hospital Council of Grand Rapids aims to furnish free or part-pay hospital service to patients unable to provide for themselves. It is a member agency of the Welfare Union of Grand Rapids (the community financing body) and uses the three hospitals, Blodgett Memorial, Butterworth, and St. Mary's, in its work. In each case the arrangement is based as nearly as possible on an accurate and complete knowledge of the financial situation.

The council takes care of a certain class of people, but there is another very much larger class that is going into the hospitals with no ready money and is either not entitled to assistance or too proud to ask for it. Whatever the reason may be, the hospital is at a great disadvantage. There are also people who are able, but are careless in paying for hospital care. Insurance cases, liability and compensation, are frequently slow in payment, especially as the patient himself sometimes does not realize that he is entitled to a settlement.

The part-pay hospital council cases require a great deal of persistent effort to collect the agreed amount. All of these amounts are paid by the hospital council to the hospital giving the service, and collections made are in reimbursement to the hospital council. This feature of the work led to the idea of collecting by the same methods, from persons admitted to the hospitals as private patients; that is, with the expectation of being responsible for the whole expense. At first the worker who was following the hospital council reimbursement cases handled these but it soon became evident that another worker was needed, and a little later another one, when the hospitals turned over a great many accounts. There are now three workers in the field, one who gives all her time

to the hospital council reimbursement work and two to the direct collection accounts. In 1923 there were 887 of the latter cases and collections made at a cost of fifteen and five-tenths per cent. We use this figure as an evidence of the success of the method but it really is only a very small part of it. The real indication that we are on the right track is that the hospitals have not received a complaint from any one who has been approached. There has been no feeling of resentment and no antagonism, but on the contrary very decided good-will has been developed toward the hospitals. In 1923, 5,187 calls were

made. The collection work is supported by the hospitals, that is, they pay the salaries of these two visitors, the cost and maintenance of two cars and such small incidental expenses as may be necessary.

Family case working principles are followed and conditions of all kinds discovered. Practically all the work is done by home visitation. Many times there is a large bill to be paid where there is no money and no prospect of any. This often happens through a series of misunderstandings or misrepresentations on the part of the

patient in assuming such an obligation. In such cases there is only one thing to do, namely, write it off the books.

Often mismanagement is the cause of non-payment; the income being adequate if properly managed, but inadequate under the circumstances. This gives a good opportunity to do some social service work, and frequently a readjustment of the family finances is accomplished.

In other cases where the intentions are of the best, but where the burden is too heavy and great hardship to the family results, the bill can be met only by very small payments, as small

### Grand Rapids Plan

GRAND RAPIDS, through its hospital council, which serves the three hospitals of the city, has adopted a special service system of collecting hospital accounts. The hospital council reimburses the hospitals for free and part-free care of patients unable to pay full rates.

In turn, the bills for part-pay care are placed in the hands of council workers who collect the accounts through personal visitation to the homes of the debtors. There are three workers in the field, one who gives all her time to the collecting of indebtedness to the hospital council and two who collect over-due accounts directly for the hospital. In 1923 there were 887 accounts collected directly for the hospitals.



as one dollar a week. Sometimes health conditions in the family are not good, but the fear of incurring expense prevents proper examination and treatment. Such cases are sent to a clinic where very frequently hospitalization is advised and given at the expense of the hospital council. Thus, many families have been reached who would go unnoticed were it not for this particular service.

The whole thing works out naturally, the combination of the free work, the part-pay work and the collection and readjustment of accounts act for the mutual benefit of the hospitals and the patients.

To summarize briefly, the following is our program:

(1) Administering funds for free or part-free hospital service.

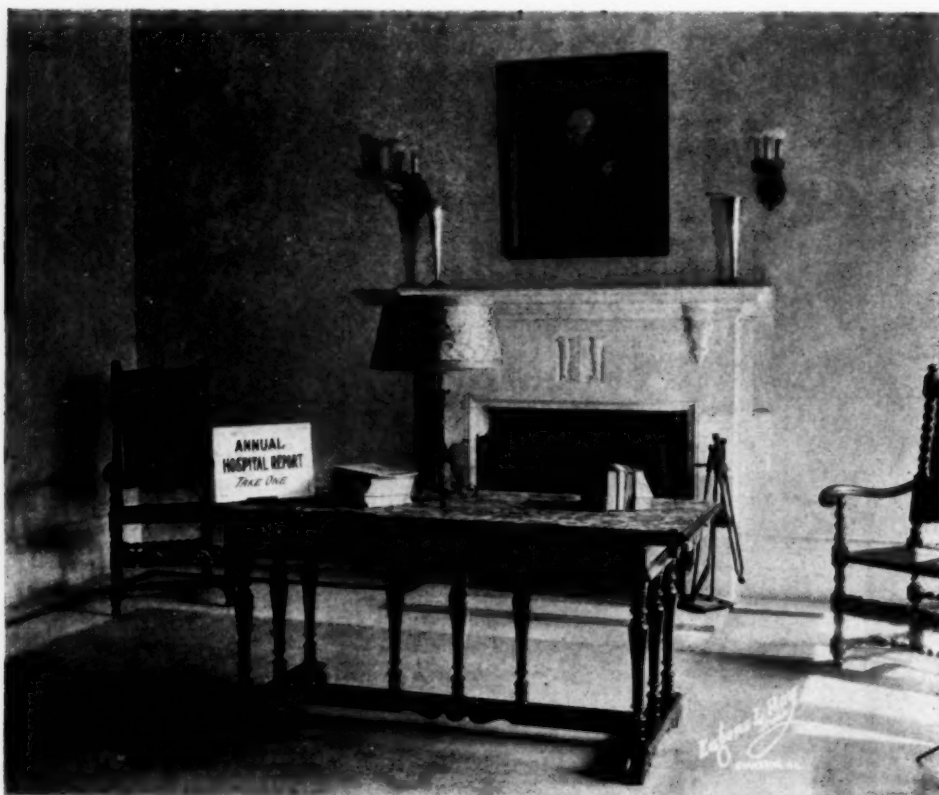
(2) Collecting unpaid hospital accounts.

(a) To avoid a feeling of antagonism on the part of the patient.

(b) To make any adjustments necessary in view of the patient's financial affairs.

(c) To secure payment from public funds, where such funds may be held responsible.

(d) To make settlements on accident cases where the patient needs such assistance.



The above picture is a view of the lobby of the Evanston Hospital, Evanston, Ill., showing the pile of the hospital's annual reports which are on the table at all times within reach of visitors who are at once attracted by the placard. This hospital has found that by placing from twenty-five to fifty copies of the annual report on the table a large group of people receive them who would not be reached through the mail. The superintendent says that by this method 3,500 reports are distributed over a period of two and a half months.

## USE OF LOCAL DRUGS IN MAJOR SURGERY IN ENGLAND

Major operations are now for the first time being performed in England with the use of a drug which does not deprive the patient of consciousness. At one of the London hospitals recently a man had two-thirds of his stomach removed, and although he was conscious all the time, did not feel the slightest pain. So well was he after the operation that three hours later he asked if he could have a smoke. The great advantages of the new method are that there are none of the unpleasant after-effects which accompany the use of a general anesthetic, and there is an entire absence of shock, because the nerves at the part where the tissues are cut refrain from acting, and do not send any messages of pain to the brain. It can be used in the case of patients suffering from heart weakness, where a general anesthetic would be impossible. The drug is injected into the back in the case of abdominal operations and in the side of the neck in the case of cancer of the tongue, throat or lip. The patient does not experience any unpleasantness, as his eyes are covered and his ears plugged.—*The Alfred*, June, 1924.

## HOME HOSPITAL FOR SICK INFANTS

Certain types of illness rarely thrive under ordinary hospital care. A peculiar aptitude is required for the successful nursing of delicate and sick infants. Many nurses, in spite of training, never acquire this training. Some years ago I tried the plan of sending out babies who were not doing well to some of the boarding homes in my Speedwell units. As the results were no better than those of hospital treatment, the practice was discontinued. More recently, the plan has been worked out somewhat differently by selecting a number of homes with especially efficient foster mothers, who under special instruction could adapt themselves to such a work and thus form home hospitals. I now believe there is a promising future for this plan in dealing with many cases of sickness in babies that would otherwise be consigned to the hospital. The plan has the additional advantage of being comparatively inexpensive in reference to the results obtained. The plan is one that can be operated anywhere and everywhere without any outlay of capital; it stresses human service aside from bricks and mortar.—Dr. Henry Dwight Chapin, *Journal of the American Medical Association*, Aug. 2, 1924.

The hospital is merely the application of the best of human intelligence and science to the treatment of disease.  
—*New York American*.

## THE NEW CHILDREN'S HOSPITAL, COLUMBUS, OHIO

By C. E. RICHARDS OF RICHARDS, MCCARTY & BULFORD, ARCHITECTS, COLUMBUS, OHIO.

THE devoted effort of a public spirited group of men and women over a period of thirty-three years reached its crowning achievement in the opening on June 16, 1924, of a new Children's Hospital at Columbus, Ohio. The achievement of this particular aim has been the result of concentrated effort over the past eight years and has received active support from the public of the city at large—all of which augurs well for widespread usefulness and appreciation of the new institution in the future.

A small group of Columbus men and women realizing the necessity for a hospital for the needy children in the city, in 1891 organized the Children's Hospital and, in order to house the institution, secured a small hospital building, facing the city's principal park. During the first three years of the hospital's existence about 200 children were cared for. The need of the new building and the importance of enlarged and improved facilities are emphasized when it is realized that almost 7,000 cases were cared for in 1923, the last

the hospital. This bequest misled the public into believing that the hospital had sufficient funds of its own. This bequest, however, was so involved in the settlement of an estate that it may not be available for the next fifty years. The war and the resulting high cost of building further delayed the project until 1922 when a new campaign was undertaken to raise the balance required. This campaign met with success and was heartily supported by the press and the public, 35,000 people in all contributing. The delay in executing this project was not without its benefits since it induced those most interested in the planning and operation of the building to give it intensive study over a long period, and every effort has been made to make the building a model institution for its purpose.

The old hospital site was abandoned as too small and too far removed from the section of the city from which many of its patients came and a new site covering a city block near a poorer section of the city was obtained. Ample light and



Exterior view of the new Children's Hospital, Columbus, Ohio.

year of operation in the old building, which had been but slightly enlarged.

### Campaign for Funds Begun in 1916

A campaign to obtain funds for the new building was carried on in 1916 but was interfered with by the bequest of a large sum of money to

air are provided by the site itself and additional advantages of space and quiet are gained by its proximity to a small wooded park. The hospital faces south, and is bounded by streets on all sides. Since none of these streets is a through street traffic noises are decidedly mitigated. Across the street to the east the hospital has purchased ad-





One of the bed rooms.

ditional ground on which to construct a nurses' home when the funds are available.

### Building Georgian in Motive

The hospital building is a four-story and basement structure, roughly "H" shaped in plan, the sides of the "H" being the front and rear sections of the building. The exterior design is Georgian in motive. The material used is a dark red wire cut face brick with warm gray terra cotta trimming. The main entrance is in front under a large porte cochère reached by a semi-circular drive from Stone Avenue on the south. The ambulance entrance is to the basement from a paved court opening on Pendleton Avenue to the west, and the dispensary is reached through the west entrance to the front of the basement which is at sidewalk level and is sheltered by a large marquee covering a paved space to afford protection to parked baby carriages. An entrance from the east, to the north and south connecting corridor on the first floor, will afford easy access to the nurses' home, the main entrance of which will face the east court of the hospital from across Seventeenth Street, directly opposite this entrance. The ground slopes up gently from the surrounding streets and has been carefully planted with shrubbery and trees giving a pleasing setting to the building.

The building is of fireproof construction throughout. The structural frame is wall bearing reinforced concrete. Partitions are plaster on hollow terra cotta tile. All plaster is smooth finish and special hard plaster has been used to a height of five feet above the floor to prevent damage in moving furniture and equipment about. Red quarry tile floors and terrazzo base are used throughout the dispensary and ambulance receiving rooms, the dining rooms and kitchens, laboratories, and x-ray department. Storage and other

service rooms have cement floors and base. All other floors in corridors, rooms and offices, the majority of the floors in the hospital, have a terrazzo base and border and naturized rubber flooring. This flooring appears to be ideal for the purpose used, as it is noiseless, easily cleaned, attractive in appearance, and adaptable to decorative effects. Bed stops are formed in terrazzo base as a further protection against the marring of walls. Stairways are of steel, finished in terrazzo with alundum treads. Toilet rooms have floors and base of terrazzo with marble wainscoting and partitions. Utility rooms and diet kitchens have terrazzo floors and base. The operating rooms have gray quarry tile floors with gray Tennessee marble walls and plastered ceilings.

### Vacuum Steam Heating System

Heating of the building is by an automatically regulated vacuum steam system, and ventilation of the toilets, laboratories, operating rooms, diet kitchens, laundry and kitchen by an exhaust system through fans in the attic. A vacuum cleaning system, is provided with the machine located in the boiler room. An air compressor in the boiler room supplies compressed air to the laboratories; dental, eye and ear, and nose and throat clinics; surgical dressing rooms; and operating rooms. A refrigerating plant in the sub-basement circulates brine through cooling coils in the refrigerators throughout the building and an ice freezing tank in the sub-basement.

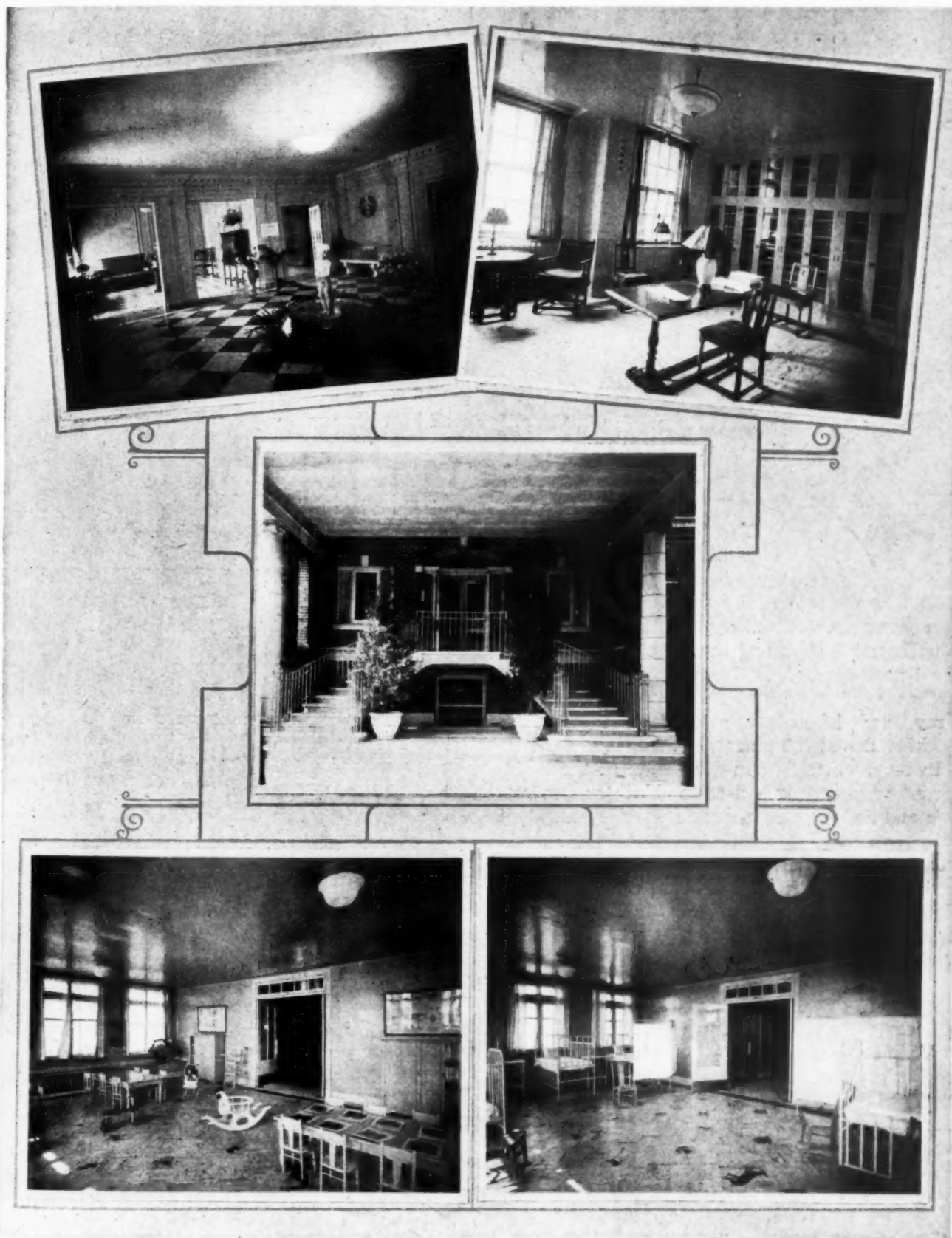
Public telephone connections through a main switchboard in the general office are provided to all administrative offices and to a telephone booth on each floor. A private automatic telephone system furnishes thorough intercommunicating service. Silent call signal systems are provided for doctors, nurses and patients. Toilet fixtures of



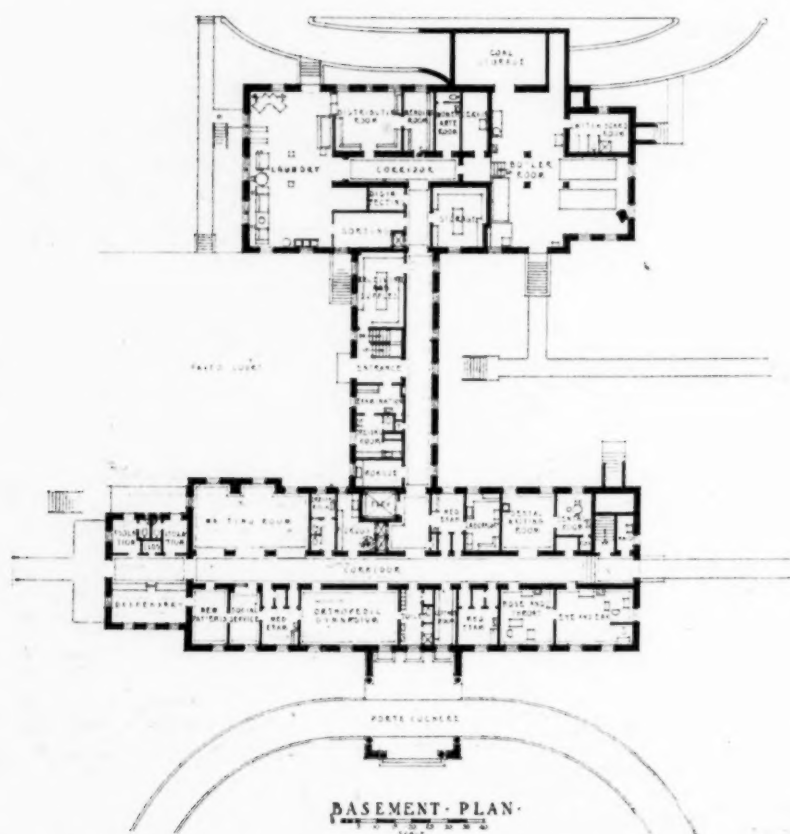
Operating room.



POINTS OF INTEREST IN THE NEW CHILDREN'S HOSPITAL, COLUMBUS, OHIO



(Upper left) Main lobby and reception room; (upper right) staff room; (center) main entrance; (lower left) second floor solarium; (lower right) nursery—fourth floor solarium.



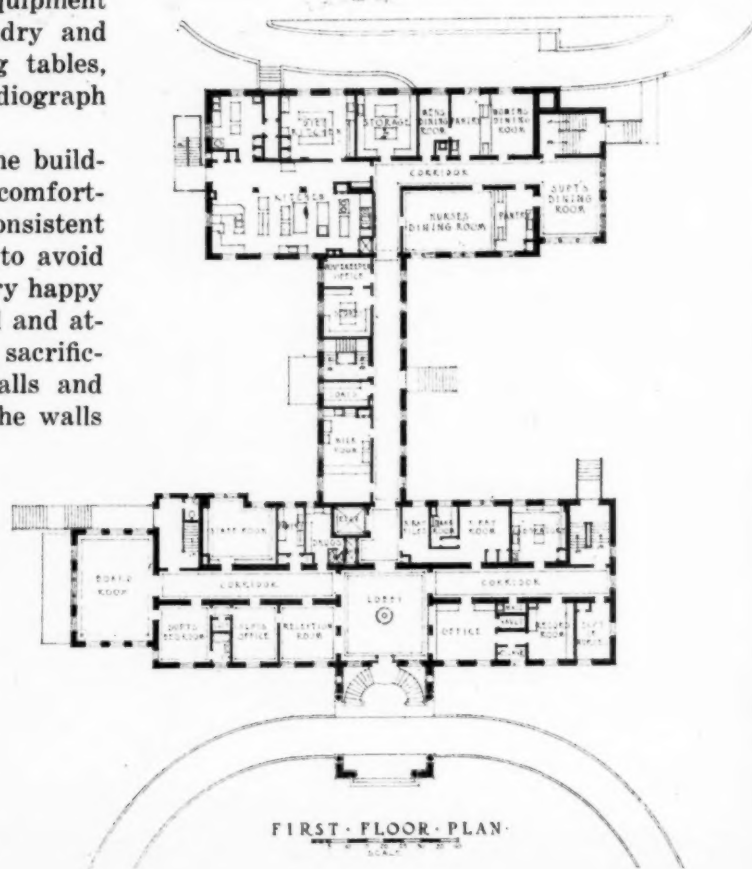
special size and design for the use of children have been provided throughout in the patients' toilet rooms. New and most modern equipment has been provided in the way of laundry and kitchen machinery, sterilizers, operating tables, x-ray, and laboratory equipment, cardiograph machine, dental equipment, etc.

In the furnishing and decoration of the building care has been exercised to obtain as comfortable and homelike an appearance as is consistent with the uses of the various rooms and to avoid a barren, institutional appearance. A very happy medium in this respect has been achieved and attractiveness has been arrived at without sacrificing simplicity and easy sanitation. Walls and woodwork are enameled. The color of the walls is a soft gray green with the woodwork ivory. Gayly colored hangings, pictures and furniture are used in the children's solariums, and color notes introduced in the furniture and hangings in all the public and living rooms of the hospital lend warmth and interest to every room. Credit must be given to the talent and taste of the members of the women's board of the hospital under whose immediate supervision the interior decorating was executed.

The dispensary and out-patient department of the hospital is located in

the front section of the basement in a compact unit affording easy supervision and efficient operation, without interfering with any other department of the hospital. Easy circulation through the department is obtained along the front corridor with an exit at the east end. The basement is virtually a ground floor, as it is set well up out of the ground to afford ample light and air. Immediately inside the entrance is the dispensary office with two isolation rooms where patients suspected of contagious diseases may be put for observation, and from which there are direct exits to the outside so that patients may be sent out without again entering the hospital. There is a large waiting room which can be supervised by the social worker or her assistant from her office across the corridor through the glass office partition. Between the general dispensary office and the office of the social service worker is an office for the interviewing and recording of

new patients. Further along the corridor are three medical examination rooms; the orthopedic





gymnasium; eye and ear, nose and throat, and dental clinics, the latter with its own waiting room; the dispensary laboratory; a drug room; dressing room and toilet.

The ambulance entrance opening on the paved court from the central section of the building serves also as a receiving entrance for supplies. Supplies are routed toward the rear of the building through the receiving and supplies room at the right of the entrance while the examination and dressing rooms for ambulance cases are located on the left toward the front of the building.

### Flooring Naturized Rubber

The administrative offices are in the front section of the first story. The main entrance is up a flight of stone steps from the drive and opens into an attractive and spacious lobby. The attractiveness of the interior decoration is most apparent in the entrance lobby and reception room which give the impression of the reception rooms of a dignified private residence. A white marble figure of a bathing boy occupies a deep blue tile fountain basin in the center of the lobby while each of the large panels on the north wall is decorated with a polychrome terra cotta plaque in the manner of a della Robbia bambino, the insignia of the hospital. The flooring in the lobby is of naturized rubber tile having the decorative effect of black and white marble. The walls are wainscotted in wood with plaster panels between the pilasters supporting the heavy wood cornice.

In addition to the administrative offices, this section of the building also contains those departments which are of general utility to the institution as a whole; such as the x-ray department; the biological and pathological laboratory; the staff room, containing a fine medical library; and the milk room, for the preparation of feeding formulas both for children in the hospital and to be issued through the dispensary.

At the west end of the front corridor on each floor above the basement is a large solarium. On the first floor this solarium serves as the board room for meetings of the women's board and board of trustees, and for a living room in connection with the superintendent's suite at other times. On the second and third floors each solarium is fitted as a play room with small tables and chairs; boxes of toys under the window seats; cases of books; gayly colored pictures on the walls; and animals, both strange and familiar, molded in the rubber tiling of the floor—a veritable children's paradise to most of the small patients of this institution. The fourth floor solarium is the nursery for babies.



· SECOND FLOOR PLAN  
SCALE

### Third Floor for Pay Patients

The second and third floors in the front section are devoted to wards and private rooms for patients. Over the porte cochère is a screened-in space for patients requiring outdoor treatment, furnished with fantastic but very usable furniture recalling many characters of childhood classics. On the second floor is the isolation and observation ward so necessary in this type of hospital, with every facility for avoiding the spread of contagion. The third floor is devoted to pay patients. This is a new departure in the Children's Hospital, the old institution having been devoted to charity cases only. With the increased facilities now available these beds have been provided through the realization that the special facilities of this hospital for the treatment of children give it an advantage over the general hospitals, of which pay patients are anxious to take advantage.

Although not thus equipped at the present time, the rear section of the third floor has been designed for a maternity department as is shown on the plans. This department again is a self-contained unit which can be isolated from the rest of the hospital. This section is equipped with soundproof doors and all partitions and plumbing for the future arrangement have been built in so that the installation of equipment can be made





Since the hospital has an endowed income of only \$12,000 a year, and since it has been the aim of the hospital to avoid making annual appeals to the public for large sums of money to maintain the work, it depends entirely for maintenance on the financial aid given by the trustees, women's board, pleasure guild, and twigs. The latter are small clubs of women throughout the city who devote their efforts to the support of the hospital through the raising of money or the furnishing of supplies. The greatest help of all is the constant and unselfish service of the medical and surgical staff who do their work absolutely without remuneration.

A social worker is employed by the hospital to follow up cases discharged as cured, to see that conditions in the home are such that there will be no recurrence of the disease from which the child originally suffered, and to instruct and advise the parents how to do the best for their children.

#### NEW HOSPITAL FOR JOINT DISEASES TO OPEN OCTOBER 5

Announcement has been made that the new Hospital for Joint Diseases, New York, N. Y., the largest hospital in the world especially devoted to the care of the lame, is to be opened October 5. The hospital has been in the process of construction for the past two years. It has a capacity of 275 beds and facilities for treating 1,500 patients a day, with a total of 165 physicians on its house, hospital, dispensing, and consulting staffs. The hospital is supported by the Federation for the Support of Jewish Charities. Dr. Henry W. Frauenthal, founder of the institution, will be physician and surgeon-in-chief, Mr. Lewis Strauss, president, and Mr. Oliver F. Bartine, superintendent of the hospital.

In 1904, Dr. Frauenthal established a little clinic at 558

Lexington Avenue, to put into practice certain theories for the treatment of bone and joint disorders with special recognition of their frequent cause in preceding bacteriological and pathological conditions, such as social diseases and others. The present institution has grown out of that little clinic.

The original Hospital for Joint Diseases was established with seven beds, in 1906. It expanded steadily through the conversion of one private house after another on the site of what is now the new hospital, until the erection of the modern seven-story dispensary building on 123rd Street, which has housed the organization during the present building period, became a necessity in 1914.

In order to make the new hospital as nearly self-supporting as possible, it will be the first orthopedic hospital in the United States originally designed to provide for private patients. Seventy-five of the beds will be in private rooms. The rest are ward beds.

Two of the beds were recently endowed by the Rotary Club of New York, and a local lodge of the Elks has just announced the endowment of a third.

The hospital also contains large chemical, pathological, and bacteriological laboratories. The amphitheatre operating room, equipped with "bicycle seats" to admit the largest possible number of visiting surgeons, redlight signals on poison cabinets, ward units that can be converted into complete shut-off hospitals for children in case of a contagious outbreak, are some of the features of the new building. Complete equipment for the treatment of orthopedic cases, from x-ray, baking, and electrical treatment machines to the most advanced surgical devices, will be provided.

The average daily cost per patient at the Indianapolis City Hospital, Indianapolis, Ind., in 1923 was \$3.50, a figure at least sixty cents lower than that of any other hospital of the same classification in the country, according to a report recently made public by Dr. Cleon Nafe, superintendent. Dr. Nafe pointed out that the average cost in hospitals throughout the country was \$5.15 for the same period.



*General View of Ancon and Ancon Hospital.*

Airplane view of the Ancon Hospital, Ancon, C. Z., conceded to be the greatest hospital in the Tropics and one of the most beautiful hospitals in the world.

## TYPOGRAPHY IN HOSPITAL PUBLICITY\*

By RALPH WELLES KEELER, COUNSELLOR IN PUBLICITY OF THE BOARD OF HOSPITALS AND HOMES OF THE METHODIST EPISCOPAL CHURCH, NEW YORK, N. Y.

**T**HE man who is captivated by the appearance of a piece of printed matter that falls into his hands seldom gives thought concerning what it is that makes it attractive. He is certain of one thing, that it delights his eye. But why? Seldom does he give thought to answering that question.

However, those who are interested in having what they send forth in leaflet or booklet, possess the something which attracts, must study the question. Nay, more, it is of vital importance that they find a satisfactory answer. For there are tons and tons of pages of printed propaganda that are never read. They are received through the mail, put into one's hand's at meetings and on the street car and subway, yet a casual glance is all that is ever vouchsafed them. Those who gather up old paper collect this printed matter and it goes on through the process of being transformed into new blank pages without ever having performed the service promised by its first venture into the world.

At times this failure is due to the fact that the printed page contains very little that is of interest, and this fault lies with the one who wrote the "copy." He either had a dull, uninteresting lot of facts to present, or else he did not have the inspiration or ability to make interesting facts pass before the eye in an attractive manner. But the same sad end befalls many pieces of propaganda literature that is written in an interesting, human or even breezy style. The trouble is that not enough thought has been given to the typographical garments the ideas and appeal are to wear.

It is right here that one is reminded again that

getting out successful hospital publicity is not an afternoon's lark or something that can be done between lunch and a two o'clock conference. For the typographical garments of an idea or presentation are as important as the subject matter set forth. Clothes may not "make the man," but they make the man relatively attractive or unattractive. The "movies" have a lesson for us here. You have observed that no matter how ragged and unattractive the heroine may be in the early reels of the picture, her innate beauty is brought out toward the end by clothes that make her appear at her best, a careful arrangement of her hair and a background that is in keeping with her changed appearance and new surroundings.

Type, the little bits of metal which hand typesetters, linotypers, monotype machinists and make-up men spend their working hours with, are the clothes and hair dress and background which make our hospital publicity go forth looking like Raggedy Ann or else like Marion Davies when dressed for her most captivating screen adventure. To some, the matter of studying such insignificant things as type, is a waste of time. "Let the printer attend to that," they say. But, alas! The printer many times has no broad conception of type styles.

He is often like the girl

who sews on beautiful dresses. Her work is just one stitch after another. His is to get the day's work in and collect his wages. That is why we hear such expressions as "a country printer's job." The selection of type and the make-up is a reflection of the printer's narrow experience and sometimes of his inability to take any suggestions from the one who's job of printing he is doing.

The meaningless mess known as "printers' pi,"

### Fitting the Suit to the Publicity

**T**YPOGRAPHY should be an important consideration in any piece of printed matter, but in particular, in printed publicity. As Mr. Keeler puts it, it is the suit of clothes with which the messenger in print garbs himself. For this reason the style of type should be fittingly attractive and not distractingly attractive, as is too often the case.

Too many persons, in selecting type for publicity material, lay so much emphasis on the attention arresting idea that they resort to all manner of exotic styles of type which can give only a freakish appearance to the whole set-up.

It is hard to strike a happy medium between what is deadly monotony in the use of the same, perhaps unsuited, type face and the lavish use of queer faces which distract rather than attract the reader.

\*This is the fourteenth of a series of articles on hospital publicity prepared for THE MODERN HOSPITAL, by Mr. Keeler.



where a lot of type has fallen into disorderly confusion, is as meaningful to some as is the line of type set orderly and well. This should never be the case with a hospital publicity man. He should understand type. He should spend hours in communion with the type faces. They should be such intimate comrades of his thinking that when a new leaflet is in process he knows at once which of his friends he will entrust with the making of a garment which shall be worn out among a sometimes none too appreciative public.

### Consider the Reader's Eyes

Type is as variable as human nature. It comes in styles, with referring to their "face" or the impression they make upon the printed page. It comes in "point," which refers to its size. It comes "bold faced," which means that it is printed very black. It appears in "italics" when it has a leaning attitude. These characteristics of type give occasion for thought, for if people are to read what is printed it must be in typographical dress so that it will be pleasing to the eye and not be a strain in any way.

Never try to be eccentric with type. It may be a fascinating pastime to you, but it will not appeal to the average reader. And it is the average reader that must be taken into account. Since we are a nation of eye-glasses, it is well to bear in mind that with the natural strain put on the eyes of a reading people, we should have our publicity printed in type that never makes the reader think of his eyes.

For example, take the following in the type as it is set up for leaflet use:

There are only three hospitals in all New England, apart from state and municipal, for the care of cancer patients.

Palmer Memorial Hospital, at Roxbury, is one of these.

Here each patient has a single room, and twenty nurses render Christ-like service.

No longer able to support themselves, these patients are dependent upon others.

Note the difference when these four short paragraphs are run into one and set up in smaller type:

There are only three hospitals in all New England, apart from state and municipal, for the care of cancer patients. Palmer Memorial Hospital, at Roxbury, is one of these. Here each patient has a single room, and twenty nurses render Christ-like service. No longer able to support themselves, these patients are dependent on others.

The first set-up is in twelve point Old Style No. 15, leaded, with extra leading between paragraphs. The second set-up is in eight point Old

Style No. 1, set solid, and run into one paragraph.

The type used in the first set-up would be read if the leaflet were reasonably short. But if the same material were printed in the second set-up very few would give heed to it at all.

### Economy No Excuse for Poor Type

A goodly per cent of the publicity material of hospitals as well as of other institutions fails at this important point. If the material prepared for a leaflet that must be included will take six pages of space of the size leaflet decided upon, and a decision has been made not to have the leaflet exceed four pages, the tendency is to set the six pages of material small enough to go on four pages. The result is disastrous. A few dollars are saved and the entire job is made useless. It is far better to use six pages or else spend two or three days in rewriting so that the finished copy will go on the four pages in a size type that will get the message read.

This takes time. Indeed the day will come when the publicity man will be counting the number of letters he can get into a line of a certain size type and then counting the letters in his copy. He will look upon the possibilities of getting one more word into the leaflet as an achievement worthy of his best efforts. Rewriting a paragraph or the entire leaflet a dozen times will be a joy to him if when he has finished he is able to send his production forth into the world dressed in type that will arrest attention and make one wish to investigate the idea that saunters out in such an appealing manner.

### Dress for the Occasion

There are some who are responsible for printed material who become slaves to certain styles and sizes of type. The result is that no matter whether it is a printed letter, an annual report, a leaflet or booklet or a poster, what they send forth is garbed in the self-same style of garments.

Yet these same individuals would be most careful not to wear their golf clothes to a formal dinner; nor would they wear full dress to watch the firemen's parade. Why not recognize the fitness of things in the use of type? Lovers of large type insist in setting up a printed letter in large type with the result that some letters freighted with worthwhile ideas look like handbills for a magic lantern show. When printing a letter, type should be used that is somewhere near the size of the type used on the typewriter, neither too small nor too large. And it is usually better to use a font of type that gives a facsimile of typewriter type rather than type used for reports, leaflets, etc. While the eye is not deceived

so that the reader believes that it is an individually written letter, nevertheless it has a much more lettery look, and when reading what purports to be a letter such a detail is of considerable importance.

#### Clearness—the Important Objective

The important thing about the type used in an annual report is clearness, so that the reader is not bothered by the type itself. Many reports are so set up that the eye is strained in reading even the body of the report, while much of the most important material is *emphasized* by being set in such small type that it is passed over without a reading. The style and size of type used in the contributed section of THE MODERN HOSPITAL are worth study at this point. No one wearies in the process of reading with such type carrying the story one wants to present. The difference is soon noticed by turning back to the departmental section where a smaller type is used and where it is more difficult to follow what one is reading. In the report there is also opportunity for the use of display type. That is, the setting up of small important sections or items in the report so that they stand out by themselves as a separate idea, and hence have special attention drawn to them. When this is done, it is usually best to devote an entire page to the display. But when well done and scattered judiciously throughout the report, these display pages help wonderfully to liven up the dead march of the paragraphs of some material which must be included in order that history may be complete.

#### Have More Than One Suit

There are many people who have several suits of clothes, but because they are all the same cut and the same material appear almost the same. One of the characters in Fulton Oursler's new novel, "Behold This Dreamer," expresses the feeling most of us have when he says: "For the last three years—day in, day out, as Clara says—I've been looking at that old maid in a blue dress, until I'm tired of it. She wears a blue serge dress until it wears out, and then she buys another one just like it. It gets tiresome." And one thing a hospital cannot afford is to have its publicity material become tiresome to those to whom it is sent. There are certain pedantic heads of institutions who pride themselves on the fact that every bit of printed matter sent out bears the same ear marks, is so like what has gone before, as to style, set-up and general appearances, that every one receiving it will know at once what it is and where it came from. Such individuals overlook the element of surprise, interest, or pull that must

characterize everything to which the average man or woman is willing to give even passing attention. Those receiving hospital literature that is always of the same size, with pictures arranged the same way, with the same style and size of type—the same dead level each time—will very soon throw it in the waste basket as soon as it arrives. They will come to think that they have seen it before, and hence save time by not examining it to make certain.

#### Two Types of Leaflets

The leaflet offers wide scope for variety in type of dress. There are, in general, two types of leaflets. One is a long discussion of some particular subject which needs considerable space to present the subject. The danger here is that the length of the leaflet will kill its chances of being read. The hope for a reading lies in the ability of the writer of the leaflet to make it so interesting that the reader will not notice that he is reading a longer leaflet than is his wont. About all that can be done in regard to type in such leaflets is to select a good readable type, break up the long journey from page one to the end with frequent and compelling subheads, and surround the type page with respectable size margins.

The other type of leaflet approaches advertising. That is, it aims to be short. It has a dominant idea that it seeks to get across. It avoids the detours of the longer leaflet. It comes smashing into our presence with a fresh, alluring appeal and is so written and set up that we have read it and grasped its meaning in the time usually necessary for deciding whether or not to feed the waste basket with it. The use of the four or six-page leaflet allows of dressing an idea up in attractive set-up. For the message is brief. It must catch the eye at the first glance. And it must be of such appearance as to hold the eye to the finish. When a hospital publicity man varies his leaflets so that each one causes the reader to wonder what new organization has put him on its mailing list, the results that are possible are secured.

One of the most profitable studies along this line for a publicity man is the careful examination of the advertising pages of THE MODERN HOSPITAL. Here almost every variety of set-up and style of type are used. Combinations are seen in comparison. Those not desirable soon manifest themselves, while one turns back again and again to the well written and set-up advertisement, from sheer joy at its appearance. Collect all the leaflets you see lying around in public places. Turn over the advertising pages of other magazines. Then study what particular style of



set-up and type will best carry the idea you wish to get across. This is important. For just as all people cannot wear the same style of clothes, so are ideas surrounded by limitations when it comes to the type and set-up that will best give expression to them. And bear in mind always that "smart-aleck" displays are the sort of thing that interest only their producer.

The typography of a booklet demands the same careful study that has been stressed for these other forms of printed matter. There is no reason why the booklets sent out by hospitals should not have as an attractive appearance as those produced by banks and business houses. They have as interesting a story to tell and as strong an appeal to make. It all depends on the willingness of the publicity man to give heed to this phase of his work and not "let the printer decide on the type."

There is not quite so wide a range of possible type usage for the poster though, even here, a study of posters will convince the observing that a goodly series of posters can be produced without duplicating the style of set-up.

### Use a Type Book

Do you laugh at the man who reads a page in the dictionary every day in order to amplify his vocabulary? Then do something that will give him a chance to laugh at you. Buy a good type book and study it daily. You will get usable knowledge which will make you willing to let him have his laugh, just as he is getting values from the dictionary of which you are entirely ignorant. Your daily study of the type book will familiarize you with type, its habits and ways of helping to express the words which clothe the ideas you are using as publicity material. You will be able to discuss your type ideas with the printer with an assurance that will discourage his "but this other type face is just as good." You will come to know what you want and no more have to say to the printer "I want to get out a leaflet. How would you suggest setting it up?" The printing side of your task will become a real joy, because you know it.

### Type Flexibility Desirable

The danger signal is always set for the publicity man who has no flexibility in his type thinking and usage. If, because one piece of literature has been successful because of its attractive type dress, he makes it his standard, he is doomed. It is worth the additional cost for typesetting to have a leaflet reset in a second style at times in order to see the contrast and discover which is the better of the two. Though if one will study type, he will soon become so proficient as to be

able to see in his mind just how a certain piece of copy will look set up in a certain style and size of type. But only practice will make this possible.

One-track minds not only become addicted to certain type, they also develop a mania for emphasis. They get to be like public speakers who yell at places in their speech they wish to stand out above the rest of their discourse. Then, finding so much that they would like to emphasize, they begin to yell during practically all of the time that they are speaking. This necessitates louder yelling for the most important passages, and the presentation becomes an incoherent scream. There is great danger in the beginning of the use of italics, bold face type and capital letters to attract attention to words and phrases. The exclamation point might be added to this list as well.

First of all, the appearance of the page is spoiled. And second, the emphasis sought is likely to be lost. The final effect on the reader is exceedingly bad. The following set-ups will illustrate the way this atrocious habit may develop.

*One hundred thousand Americans die annually from cancer!*

But this does not emphasize some other things that are important. So

*One hundred thousand Americans die annually from cancer!*

Even this leaves an important item in the background. Thus the habit takes on the following

*One hundred thousand Americans DIE ANNUALLY from cancer!!*

There is nothing left for the reader. Whereas, if the statement had been set up without the italics, capitals, bold face and exclamation points, the content of the statement would have made its own appeal.

### The Romance of Type

Type is alive with romance to him who hath eyes to see. To those dull of vision, however, type is merely so much metal, necessary of course to the printing trade, but of no particular interest to a full-fledged publicity man. What a pity that there are such people still with us! And how sad that there are some hospital executives so short-sighted as to veto the purchasing of such tools as type books, magazines on printing and other material necessary for a publicity man to be fully equipped for his task!

But those who see romance in type are increasing. This is most encouraging, for it is they who are to make our hospital literature glow with garments which conform to the thought expressed.

They will see to it that the type used is in accordance with the purpose of the particular piece of literature. They will help to make it a boast that as much skill and thought is put into hospital literature as into that advertising ham, soap, cream cheese and shoe polish. They will turn the eyes of the community expectantly toward the literature output from the hospital. They will do much to increase the number of hospital executives who are convinced that special training and experience are essential for the doing of the full task of hospital publicity.

Whether it be linotype slug, monotype or type hand set from a case, the type which is to carry your message so important to you, salutes you. It does not ask much in return for its greeting. But the more attention given to it, the better will it serve you. The wise hospital publicity man will tarry long enough in the greeting to know each of them by name. In the hour of rushing some piece of copy off for printing he will find that knowing the type is an ally without which he can not hope to make his product second to none. This is vital to successful publicity.

#### HOSPITALS NOT MENTIONED IN MAJORITY OF WILLS

That hospitals are seldom mentioned in the wills of any but very wealthy people and the need that hospitals of this country have of donations from persons of moderate means are facts strikingly brought out by Dr. John R. Williams, chief physician, Highland Hospital, Rochester, N. Y., in an article "Make Provision in Your Will for Better Hospitals," in the September issue of *Hygeia*. Dr. Williams says in part:

"Persons in moderate circumstances rarely make gifts to institutions probably because it is feared that small bequest may excite invidious comment, perhaps more often because it is not the custom. . . .

"Very few persons realize the character of service that hospitals now render or the cost thereof. Donations and funds raised by such organizations as community chests are designed to take care of current needs and can only be used for that purpose. They are insufficient and do not provide for the growth and scientific development of hospitals.

"Money for this purpose must come from private beneficence and since such gifts are few, hospitals are generally hampered by lack of financial means. Overcrowding due to insufficient beds, is common. Every day sick people are turned away because of lack of adequate facilities for their care. . . .

"Here and there will be found hospitals equipped for the investigation of disease and occasionally there will be seen a struggling inspired worker, but the institutions for such study and the individuals engaged in it are far too few and the problems to be solved without number. . . .

"Every citizen should feel duty bound to aid research along the lines that will conserve human lives and prevent suffering. We owe it to ourselves. Even if we escape the dreadful diseases of childhood, the causes and

treatment of which are very imperfectly understood, we are quite likely to fall prey to the degenerative diseases of adult life which are even less well understood.

"One way, a most magnificent way, in which we can do this is by making a will providing for or helping promote scientific study to the end that those who follow us shall not be called on to suffer as have we or to die prematurely without having a fair chance for life."

Dr. Williams enumerates three ways by which hospitals can be helped by bequests:

(1) Through an endowment to meet the current financial needs; that is, to meet the annual deficit caused by taking care of a large number of persons in moderate circumstances at less than cost.

(2) Through extension of hospital facilities by the addition of new buildings and equipment.

(3) Through medical investigations and research.

He goes on to say that a person in very moderate circumstances might leave a sum ever so small for any of the aforementioned purposes. If the sum in itself is inadequate, it can be added to other sums left for a similar purpose, so that the aggregate of many small bequests may in the end be the same as a large contribution. Gifts of from \$10 to \$100 from a large number of so-called middle-class people would afford evidence of the growing spirit of humanitarianism and brotherhood. To those who can afford more liberal bequests as, for instance, \$1,000 and upward, provision can be made for the support of fellowships in medical research in hospital laboratories. Dr. Williams brings out that by no other means can one secure for himself or his loved ones a more enduring monument than is offered in hospital aid and endowment.

#### CAMPAIGN FOR FUNDS TO ENLARGE AMERICAN HOSPITAL IN PARIS

The American colony in Paris has opened a subscription for funds needed to complete the memorial building which is adjoined to the American Hospital of Paris. Hon. Myron T. Herrick, U. S. Ambassador and consul-general, and Mr. A. M. Thackera, are at the head of the committee, of which Mr. Charles F. Greene is the president. The American Hospital is located at Neuilly-sur-Seine, occupying a portion of the old site of Neuilly Park, and includes an area of about 1,500 square meters.

The present hospital contains only thirty-two beds, and is not adequate to the needs of the Americans living in France or in Europe, together with the tourists and those who go there on business. It is planned to increase the bed capacity to 120. The sum of \$1,097,000 will be required to complete the buildings and provide for their equipment. Of this sum approximately half still needs to be subscribed. Subscriptions may be sent to any one of the American banks in Paris charged with the collections of the funds.

#### CORNELL CLINIC HAS NEW MANUAL FOR MEDICAL STAFF

The Cornell Clinic, New York, N. Y., has recently issued a fourteen page manual for the staff of the medical department. The manual is divided into ten sections as follows: clinic organization and purpose; medical department staff; clinic sessions and admission of patients; relationship of doctor and patients; the clinic executive; the nurse; the service departments; records; interdepartment relations; and consultation within the department. Copies of the manual may be obtained from Dr. Calvin H. Goddard, director of the clinic.



## THE ESTABLISHMENT AND MANAGEMENT OF A MEDICAL RESEARCH INSTITUTION

BY HENRY C. SWEANY, M.D., MEDICAL DIRECTOR OF RESEARCH, CHICAGO MUNICIPAL TUBERCULOSIS SANITARIUM, CHICAGO, ILL.

**I**N ATTEMPTING to describe the organization and conduct of a medical research laboratory one should be endowed with either a broad experience or a good imagination. Having no great abundance of either, we keenly feel our inability to render a proper presentation of the subject. Nevertheless, it has been our good fortune to be intrusted with the task of establishing a research institution in connection with the Chicago Municipal Tuberculosis Sanitarium, in the course of which we have acquired much information that may, perchance, be useful to others. At the outset, let us make it clear that our work was the completion of work begun by various men, the details of which cannot be entered into here.

In dealing with this subject we may conveniently divide it into four phases: construction, equipment, personnel and management.

### Chemistry Department is Hub

Medical research must of necessity deal with the study, prevention and treatment of disease of living organisms, principally human beings. Therefore fundamental biological principles must

functions of the living body and the various deviations from the normal—physiology and pathologic physiology; the exogenous forces that cause disease—bacteriology, parasitology, toxicology; the study of the effect of substances that help nature correct deviation from normal—pharmacology and therapeutics and, finally, an ever-growing knowledge of the ultimate constitution of all these factors and the laws and forces governing them, that is, physics and chemistry.

These various groups should be in close relation to one another and must effect a liaison with one another, but there is one group among them that is steadily increasing in importance, because all other groups are associated with and founded upon it. We refer to chemistry (and physics), particularly that part that deals with organic life. More and more are all the others being reduced to a physical and chemical basis. Not infrequently some hormone is worked out chemically; or some biological process placed on a chemical basis. Just as the old dermatological classification of eczema is vanishing into better understood clinical entities, so are various biological reactions turning

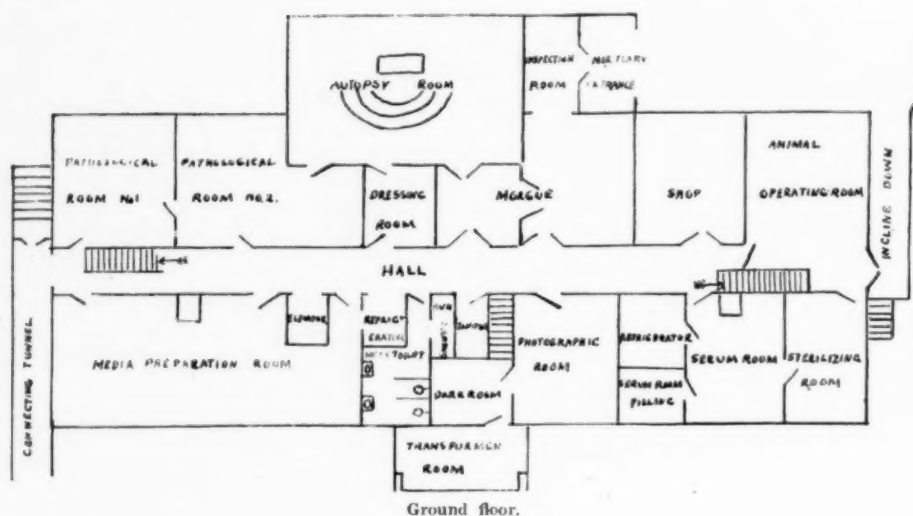


Laboratory building, Chicago Municipal Tuberculosis Sanitarium, Chicago, Ill.

form a foundation for such work, and any plan must be formulated with these in view. Such principles are dealt with by the sciences which treat of the normal structure and variation from the normal—anatomy and pathology; the normal

out to be processes of chemistry and physics.

There should be a first-class physico-chemical department with the other departments in the most convenient relation to it. In other words the chemical department should be the hub

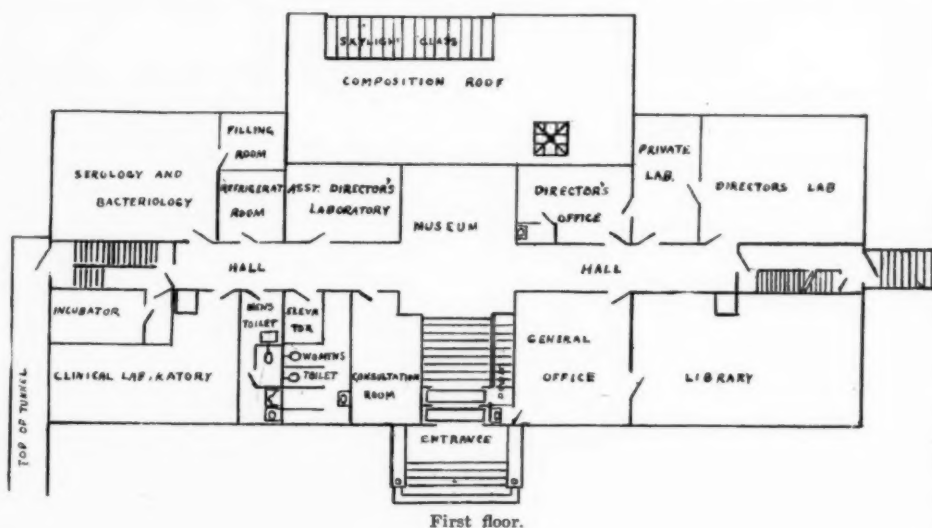


around which the spokes radiate, because it is, or should be, common to all. True, other departments are related, but not so intimately. Physiology should be closely associated with pharmacology, and pathology with bacteriology. Other departments must be placed where the greatest convenience demands. Any plan, however, should be elastic because there are indeed few institutions that are able to begin in full force. It must be, to some extent at least, an evolutionary process.

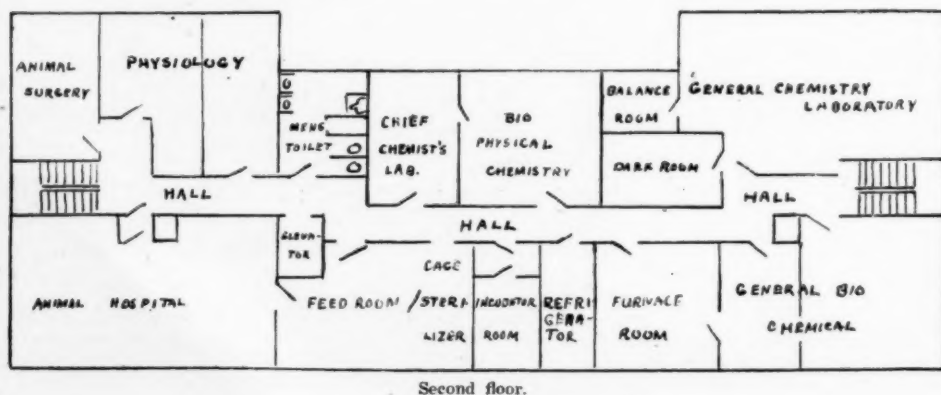
With the departments well established various workrooms should be equipped where independent workmen may proceed along special lines peculiar to the particular institution. These independent workmen, however, should be in frequent touch with the director and the various department heads so that no waste effort or duplication of work will occur.

they tend to focus on common principles and increasingly overlap each other.

The locations of other accessory departments are more or less immaterial. The office and library should be as central as possible, the store-



room accessible, but not necessarily central. Other rooms, such as photographic rooms and shop, may be selected as convenience permits so long as they answer their respective purposes.



This will also tend to do away with some of the misunderstandings that exist between some of the sister sciences, many times over a misconception of viewpoint or lack of proper definition of terms. The great trouble is that each science unavoidably works in a little world of its own and there is not an adequate conception of relativity to other sciences. This is particularly true in new fields of work. As time goes on and the sciences broaden

The accompanying plans show the way in which these various groups are arranged in our institution. As in all such projects, mistakes were made but there are very few serious ones. It is important to have a practical laboratory man work continually with the architects, otherwise function will be sacri-





Director's laboratory showing type of furniture installed.

ficed to beauty, and needless errors will be made.

The general plans having been outlined, the more detailed points may be described. The placing of sinks, faucets, refrigeration, steam radiators, electrical conduits with required voltage and amperage, gas, air, vacuum, sterilizers of all sorts, wall cases, tables and bookstacks are all matters that require individual care. In fact each room must not only be considered with regard to its relation to other rooms, but must be treated individually with regard to arrangement of apparatus in the most convenient manner. Here is where the imagination must enter in. One must anticipate the type of work to be done in each room.

#### Start with Minimum of Equipment

The laboratory furniture should be, preferably, of a uniform grade of substantial oak. Desks, tables, wall cases, and work benches should all be designed according to the need of each room. To cite specific examples, we have found that a two-shelfed wall case, three feet high by four feet long by one foot deep, having locks and glass doors placed about eighteen inches above the work bench, has been most satisfactory. Center work benches, having drawers and storage case below but elevated above the floor by ten inch legs for cleaning, have answered our purpose admirably. These tables may be high or low form (thirty inches or thirty-six inches) depending on the need. Because most work is standing work the high form is in greater demand. As a covering, alder stone is used where there is a great deal of wear; otherwise maple, oak or pine is used, depending on the amount of wear expected. If wood is used an acid-proof paint should be applied.

Most of our furniture was made on the ground by our own construction force at a cost of ap-

proximately one-half that charged by regular manufacturers. There was a still greater advantage in that plans could be made and furniture installed as necessity demanded, thus obviating superfluous and unnecessary pieces.

Space does not permit a complete description of the equipment of such an institution, because it would be nothing but a catalog of scientific material. The most modern standard equipment should be obtained for each department, leaving the special apparatus to be purchased or made up by the mechanic or glass blower as needed. This is better than having thousands of dollars laid up on the shelves in the form of antiquated and untried apparatus. Certain basic chemicals and apparatus must be obtained, but the changeable equipment should be purchased only as needed. We have solved our storeroom problem by using a modified card system for our basic stock. By this system we are able to obtain any article in a moment's time and know the quantity on hand.

#### Equipment for Biological Department

The pathology department should consist of a good autopsy room with an amphitheater for proper observation, because great good comes from the demonstration of pathological material to medical men and students. It gives the clinician a chance to check up on his work. It is an old saying that autopsies are an index of an institution's efficiency.

There should be well equipped rooms for making microscopic slides by all methods, and mounting pathological specimens for a museum. These rooms should also be near the bacteriological rooms for making cultures from fluids and tissues.

The bacteriology department should leave nothing to be desired in the line of equipment for making media and cultivating bacteria. This



Bio-chemical laboratory.

should include all sorts of sterilizers, clarifiers, incubators, inspissators, anaërobic jars, filtration apparatus, shakers, ball mills, centrifuges.

In this institution the clinical laboratory work for the hospital is done and arrangements have to be made to care for this work. Our serology work is done in the main bacteriology room, while the culture work, and sputum and urine analyses are taken care of in a special room equipped for that purpose.

The physiology department should have a room for experimental work having a good tracing outfit, and other fundamental pieces of equipment.

A well kept animal hospital should be in close proximity with facilities for caring for all ordinary laboratory animals especially dogs, rabbits and guinea pigs. Special metabolism cages, cage sterilizers, and facilities for washing dogs should also be provided. A room for sterile animal surgery must also be equipped for all kinds of animal operations. For this room we have adopted the type of apparatus used at the University of Chicago. Finally, there should be a metabolism room for human patients, with the best metabolism outfits available. Other minor pieces of apparatus should be added as necessity demands.

#### What Chemistry Department Needs

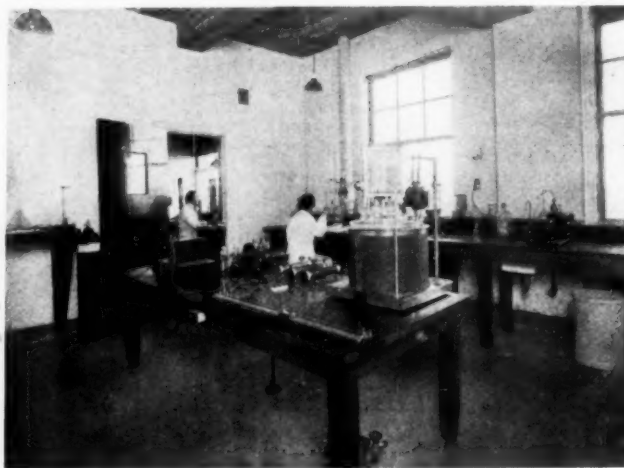
For the chemistry department there should be every device necessary for preparatory and analytical work. This should include physical apparatus for the determination of physical constants. Such apparatus includes polariscope, spectroscope, refractometer, potentiometer, conductivity apparatus, colorimeter and nephelometer.

To save further uninteresting details regarding a chemical department let it suffice to say that a complete chemical laboratory for research requires electric, bomb, and combustion furnaces, digester, vacuum oven, fume hood, thermostats, Kjeldahl apparatus, balances, centrifuges, and all similar modern equipment. There should be a room for the furnaces, a biological room, a physical-chemistry room, dark room, and balance room, as shown in diagram.

Another very important part of such an institu-

tion is the library in which ample space and material should be provided for lectures and seminar meetings, if there is not other accommodation for them. We have limited our books and periodicals to the most important ones and receive about fifty journals in all. This is done because we desire to have a practical working room rather than a reference library and, furthermore, because there are several good libraries already in the city where more exhaustive reading may be done.

Other rooms, such as an art room with facilities for photographic, photomicrographic and illustrating work; a shop where apparatus may be constructed and glass blown and various other similar rooms are valuable, but not altogether necessary.



Physical chemistry laboratory.

It makes little difference how perfect is the construction and equipment of an institution if proper workmen are not employed. Some really great structures have produced little, and many great discoveries have been worked out virtually in kitchen sinks. Apart from common sense, honesty and a minimum training, the first requisite for a laboratory technician

is industry, for without it nothing will be accomplished, even with the finest apparatus. With sufficient zeal obstacles will be overcome, and great results obtained.

The next requisite is unselfishness. In a live, pulsating institution, there must be harmony; there must be sacrifice for the common good; there must be team work, just as there must be team work on a football field and on the field of battle. Lastly, there must be youth, even though untried. Many will not develop into the spectacular, but among the neophytes of today are the Pasteurs of tomorrow and with the proper leadership and stimulation the Pasteurs will always be Pasteurs. An older man who is worth anything cannot be procured because he will already be established beyond temptation; if he can be had "for a song" he is not even worth it.

As to the management of such an institution, opinions will, no doubt, vary. Every director has his own methods and makes them work where another would fail to do so. There must be elasticity in any program, allowing the workmen to follow out their leads unhampered. Where military methods are introduced into research spon-



taneity is killed and young ideas aborted. Routine work is bad and a rut is suicide.

Weekly seminars and lectures should be held for the mutual benefit of everyone. Here new thoughts and ideas may be put through the furnace of criticism from various viewpoints. The reading of scientific literature and attendance at scientific meetings and conventions, however, should be encouraged and practiced. In fact these things are necessary for anyone who desires to remain in scientific work.

Any plan for research must indeed be a general one, for new problems that present themselves originate chiefly from the daily work of the individuals. What appears to be good before trial may turn out to be worthless or negative as much work does. Of course there are problems that can be planned out from the beginning in methodical order but some of the greatest discoveries have been accidental—accidental in a sense that the experimenter was not searching for the thing found, yet not accidental in the sense that he was alert to the unusual circumstances and took advantage of them, just as an alert football player siezes a fumbled ball and is away for the touchdown.

The young worker should not be allowed to forget that he has special senses and a plastic mind and that no ill results have ever occurred from ordinary use of them. On the contrary, the greatest discoveries have emanated from simple observations intelligently interpreted. He should be taught to investigate, thus following the worthy example of Roentgen when he first observed the bizarre phenomena afterward called x-rays.

#### MODERN PSYCHOTHERAPY TRACED TO AESCULAPIAN TEMPLES

When the darkness which enshrouds early Greek history lifts, we find a cult of the God of Healing, Aesculapius, and a society of physicians, the Asclepiadæ. The chief centers of this cult were at Trikka in Thessaly, in the island of Cos at Pergamos in Ionia, and at Epidaurus in the Peloponnesus. The temples of Asclepius were practically hospitals and sanatoriums. They were usually placed in localities favored with climatic and hygienic advantages, and often in the neighborhood of mineral springs. The chief means of cure were physical exercises, baths, inunctions, purgatives, emetics, dietetic regulations, rest, and various modes of suggestion. It is instructive to note that in the very earliest times the Greek physicians understood and stressed suggestion. They knew well the great influence of mind upon body. In the temples of Aesculapius one of the favorite methods of treatment was the temple sleep. In the silence of the night hours the physician, personating the God of Healing, visited his patients, soothed their fears, encouraged the hope of recovery, and no doubt favorably influenced the course of disease. Whether he taught them to say "I am feeling better and better every day," I am unable

to affirm; history is silent on the subject, but if the formula was different, the method and design were the same. Coué would have felt quite at home in a temple of Aesculapius, and I am not sure that Freud, Jung, Adler and their numerous followers might not have found some of their views and methods anticipated by the disciples of Aesculapius. The wheel has come full circle, and modern psychotherapy is reverting to the practice of Cos and Epidaurus.—Dr. James Alexander Lindsey in the *British Medical Journal*.

#### THE COST OF HOSPITAL CARE

It costs approximately four dollars per day per patient for hospital attention in the federal public health service. In some of the civilian hospitals in the large cities the cost is six dollars per day per patient and in many of the smaller cities it is known that the cost is not to exceed half this amount though in all probability this is due to lowered standards and lessened amount of equipment. Anyway, it goes to show that maintenance of a good hospital costs money and few, if any, hospitals are self-supporting. In the average city where the patient is charged forty to fifty dollars per week for hospital service, which does not include any private nursing, the patient gets the idea that the hospital is getting rich on such terms, whereas, as a matter of fact, the hospital generally is merely coming out even if all of the rates were alike.

With the maintenance of wards and certain rooms for the accommodation of people in moderate circumstances, which never do pay for themselves but always help to create a deficit, the hospitals are always in need of funds. On the other hand, patients who are too proud to be classified among the needy find sickness a great financial drain when the hospital charges forty to fifty dollars per week for services, an extra fifty dollars for special nurse and still extra for laboratory fees, and this all before the doctor receives anything for his services. Improvement in hospital service is greatly to be desired, but there ought to be some way by which, through standardization and economies, the cost can be reduced.—*The Journal of the Indiana State Medical Association*, July, 1924.

#### PROGRESS IN SYRIA'S HOSPITAL FOR THE MENTALLY ILL

The annual report of the Lebanon Hospital for Mental Diseases, Beyrout, Syria, for 1923-24 is of interest in showing the work done in the only hospital for mental diseases in Syria. The hospital cares for patients of a variety of races and creeds, Christians, Jews, and Moslems alike. Funds are provided by committees in various European countries and in America. The income is also maintained by grants from various local authorities towards the maintenance of their pauper patients.

The city of Damascus recently withdrew its chronic insane with the intention of attempting to maintain them in Damascus itself at a cheaper rate, but it is believed that this experiment is proving a failure.

An abundant water supply has now been obtained by sinking a well, a fact the importance of which will be appreciated when it is known that all water was previously purchased from outside and that a supply is necessary to enable the land belonging to the hospital to be cultivated. Students from the American University at Beyrout are now attending lectures and clinical demonstrations at the hospital.

Last year, in all 236 patients were under treatment.

## PSYCHOPATHIC CLINICS\*

BY A. L. JACOBY, M.D., DIRECTOR, PSYCHOPATHIC CLINIC, RECORDER'S COURT, DETROIT, MICH.

THE word hospital comes from the Latin *hospitalia*, meaning apartments for guests, and was originally used in English to denote a place for the shelter or entertainment of travelers and strangers.

Later the word came to be used in connection with charitable institutions for the refuge and maintenance of the needy, aged, or infirm. Now, of course, the use of the word hospital is practically confined to the description of institutions where the sick or injured are given medical and surgical care. In our hospitals we expect to find the very highest medical and surgical achievement, and we no longer regard the hospital as a place of entertainment, shelter or refuge, but as an active, virile force in the conservation of human well-being.

Along with this transition of function of the hospital from a place of refuge to a place of active, positive influence, there have occurred, of necessity, within the hospital, many changes. Some of these changes have come about as a direct result of advances made in the medical sciences; many of them have occurred independently of scientific advance and in response to public demand. The division of the work of the hospital into departments, in keeping with the tendency toward specialization, is a natural evolution abreast of scientific advance. The introduction of social work into the hospital has come, I believe, much more as a result of the public need than as a result of any specific scientific development. It is to be expected, then, that the hospital will assume, or have thrust upon it, more and more responsibility, and will find itself occupying an increasingly important place in the control of individual destinies.

### Hospital's Field Broadens

As civilization, so-called, develops in complexity, the hospital is called upon more and more for help in the problems of individual maladjustment. Just as the work of the physician has broadened in function from the treatment of disease of this or that organ to the conservation of health of those organs and the maintenance of human efficiency at its highest, so the hospital is broadening its function and is rapidly becoming an agent for the solution of all sorts of problems which interfere with the highest human efficiency.

In the field of neuropsychiatry there has been the same broadening of function as in all the

other fields of medicine. From the lunatic asylum of a few decades ago, concerned almost entirely with the problem of shelter and custody, has evolved the hospital for the insane with its major emphasis upon study and treatment. Out of this study has come the knowledge that many of the mental mechanisms utilized in the production of so-called insane behavior are the same mechanisms as are utilized in the determination of much of our every day conduct.

An application of this knowledge, designed to prevent mental breakdowns, has brought into being the mental hygiene movement and, more specifically, the establishment of out-patient dispensary services as units of state hospitals for the insane, and as departments in general hospitals. A tremendous impetus was given this whole movement by the experiences of the war period, so that now it is rather universally recognized that an analysis of the personality is almost the first requisite in the understanding of a particular problem of maladjustment.

### How Mental Hygiene Clinics Function

The name psychopathic clinic seems to have had its origin as an outgrowth of the term psychopathic hospital. The word "psychopathic" appears to justify its existence as an escape from the more offensive term "insane" to which there is attached, in the public mind, considerable stigma, and in connection with hospital the term is an accurate one. The psychopathic ward or hospital is a place for treatment of diseased minds, but the psychopathic clinic as applied to an out-patient dispensary or to the court clinic has come to be more or less of a misnomer, because its function is more that of prevention and conservation than of treatment. Hence we see the later clinics of similar function being termed mental hygiene clinics, or where the mental problems of childhood are especially dealt with, child guidance clinics. These terms much more accurately denote the real function served.

Personality, that sum total of characteristics which serves to set apart each man from his fellows, is now recognized as being a product of the nervous system, so that neuropsychiatry has come to extend in function much beyond the diagnosis and classification of feeble-mindedness, insanity or organic diseases of the brain or spinal cord. Mental defectiveness, psychoses or pathological conditions of the nervous system are only some of the issues to be met by the neuropsychiatrist

\*Read before Michigan Hospital Association, January 24, 1924.



in the psychopathic clinic or mental hygiene clinic. He must also advise in all matters where mental mechanisms are involved, whether the end products of the mental mechanisms fall in the category of disease or not.

### Many Backslide Into Disease

The dividing line between health and disease is becoming less and less distinct as our scientific knowledge increases. This is as true in mental medicine as in physical medicine. With our improved diagnostic methods we are noting in all fields of medicine phenomena which, with the older methods, were regarded as disease processes and which we now view as natural, normal reactions of the organism to its situation or environment.

It is essential, then, that any hospital which purports adequately to serve its community must be prepared to meet these various problems. It is not sufficient to have a neurologist on the medical staff to say whether or not a patient has tabes dorsalis, dementia præcox, or brain tumor. The neuropsychiatrist of the hospital must also be able to state why a patient with a varicocele is unable to work after his operation when his wound is completely healed. He must be able to advise the gynecologist as to whether or not the personality of the patient is such that an anterior shortening would or would not improve the patient's health and efficiency. He must be able to help to reconstruct a patient's entire philosophy of life during his hospital residence, if such a reconstruction is necessary to insure the patient's remaining socially well after discharge.

The term recidivism as applied to criminals, to connote that group of individuals whose life careers are characterized by repeated backslidings into crime, is almost equally applicable to a group of individuals, whom we all know, whose life careers are characterized by backsliding into so-called disease. When an individual of this group is viewed from the angle of his personality, rather than from the angle of his heart, or his lungs or his kidneys, we are almost invariably

able to find the reason for the backsliding, while it will never be found entirely on the basis of his individual organs. How frequently is this "flight into disease" the mechanism used by women to escape an unsatisfactory marital relationship! How frequently is the same "flight into disease" used by men to escape unduly heavy responsibilities!

To treat the disease into which the individual has flown and give no consideration to the lack of adequate adjustment between the personality and his environment is merely to temporize and is not rendering full service to the individual.

## The Mental Mechanism

Personality, that sum total of characteristics which serves to set apart each man from his fellows, is now recognized as a product of the nervous system, so that neuropsychiatry has come to extend in function much beyond the diagnosis and classification of feeble-mindedness, insanity or organic diseases of the brain or spinal cord. Mental defectiveness, psychosis or pathological conditions of the nervous system are only some of the issues to be met by the neuropsychiatrist in the psychopathic clinic or mental hygiene clinic. He must advise in all matters where mental mechanisms are involved, whether or not the end products of the mental mechanisms fall in the category of disease or purely mental abnormalities.

It is being more and more recognized that all matters of human behavior are reactions of the nervous system to a stimulus or a set of stimuli. And disease, physical as well as mental, is behavior in that same way. The pain of appendicitis is a reaction of the nervous system to certain irritations. The complete disability of one patient when he learns that he has one kidney lower than it should be, and the lack of any disability on the part of the next patient with the

same kidney displacement, are reactions of the nervous system of those individuals to that stimulus. Although the stimulus is the same in each case the reaction is totally different and the reason lies in the nervous and mental make-up of the patients. The hospital which strives to return its patients to the community as efficient, happy members of society must take cognizance of these factors and be prepared to meet them.

The recognition of the scope of neuropsychiatry, through the psychopathic clinic, is manifested by requests to the clinic for advice in the following kinds of problems:

The treatment of given cases of nervous and mental disease or defect; the disciplinary management of individuals; the selection of individuals for certain types of employment; the management of difficult domestic situations where divorce was threatened or pending; the education of industrial executives to a better understanding of their employees; the selec-

tion of credit risks by credit organizations.

In a great many, I may safely say in the majority of the individual situations falling into the groups above, there have been admixtures of disease of greater or lesser, usually lesser, severity. And not at all infrequently is the disease the immediate excuse for the social situation resulting.

As has been pointed out above, the modern hospital must be prepared to render this full measure of personality service. When it does this fully and completely we shall see a large decadence of patronage to many cults and "isms" about which some of us are prone to complain. These cults and "isms" do give the patient something which is directed at changing his viewpoint and the change is often helpful to him, in spite of the fact that the substitution brought about by the cult is often in no way based upon fact.

### Analysis of Patient's Life Necessary

A mental hygiene department or psychopathic clinic of a hospital, if properly manned, can serve these various functions. Its operation is not mysterious nor is it especially difficult. In this department there should be personnel for investigation and collecting of medical and social history, the record of past performance of the patient, including his antecedents. Such a record, if properly taken, gives us the insight into the habits of reaction of that individual's nervous system. What habit systems has he built up? Is it desirable to change them? Does the patient wish them changed? Should attempts to start new ones be made? These questions are to be answered from such an historical analysis of the patient's life. Then his native intelligence should be measured, especially if there is the slightest doubt concerning his full allotment. This is done by using the standardized psychometric tests and gives a rating relative to the average. From this examination comes some information as to his abilities to change habit systems already formed or to inculcate new ones.

Finally the neuropsychiatrist should search for disease of the nervous system and ascertain the force of the various mental mechanisms controlling his conduct. The conclusions should be a summing up, from these examinations, in the form of a statement of his kind of personality and his trends, with a common sense deduction regarding the necessary steps for the patient to take.

Exactly the same methods of deductive reasoning apply here as apply in any other field of scientific endeavor. Personality, at any given time in life, is the result of what the individual was born with and what he has lived through, just as the

physiological picture of the heart at any time is the result of what it was at birth and what it has lived through.

It is my observation that very many patients in and out of hospitals want just such service, and their adjustment cannot be begun or their future productiveness assured without it. It is essentially a medical matter and does belong in those divisions of our social scheme which are intended and equipped to handle medical matters.

### THE HOSPITAL AS A HOTEL FOR THE WELL

A delegate arriving late at night during a recent political convention in the eastern part of the country upon finding no available hotel lodging in the city told the taxicab driver to take him to a hospital. He was entered as a patient desiring an operation for appendicitis. As it was late, the usual formalities of blood examination, urinalysis, and other examinations were postponed until the following morning, when the patient declared that he felt so much better that he thought he would postpone his operation, and called for his bill. Later he boasted to his friends that he had a better bed and breakfast for the modest charge of \$3 than his friends had at the various hotels where, at convention rates, the guests were paying \$10 a day.

### MENTAL HYGIENE SURVEY OF TEXAS

The National Committee for Mental Hygiene is conducting a mental hygiene survey of Texas which will be done in three sections. The first section deals with penal institutions and is in charge of Dr. Ralph M. Chambers; the second comprising the five state hospitals for mental diseases, the state colony for feeble-minded and the state epileptic colony is in charge of Dr. George M. Kline. The third section will include 3,000 public school children, and the children in four state institutions for dependent and delinquent children. The members of the staff of the third section are being selected and its work will begin when schools open in the fall.

### INSTITUTIONAL MAINTENANCE COSTS IN INDIANA

A report on the statistics of Indiana state institutions for the quarter ending December 31, 1923, shows an average daily cost per person of \$3.35. These figures represent a summarization of costs in twenty institutions. The gross maintenance averaged \$80.39, distributed as follows: Administration, \$31.38; subsistence, \$15.88; clothing, \$3.18; office, domestic, and outdoor departments \$26.87; and ordinary repairs, \$3.08.

### CLINIC FOR CHILD STUDY AT HARTFORD

A clinic for child study has been set aside at Hartford for the use of the juvenile courts, public schools, social agencies and parents of Connecticut. The clinic which will be known as the Helen Hartley Jenkins Juvenile Clinic, will make a physical, psychological, psychiatric and social study of each child referred to it and when needed, will recommend a method of treatment. Dr. Thomas W. Salmon, professor of psychiatry, Columbia University, New York, N. Y., will conduct the clinic. Dr. Otto G. Wiedman will be medical director, and Dr. Harold A. Bancroft, assistant psychiatrist.



## THE NEW TUBERCULOSIS PAVILION AT THE STATE HOSPITAL, INDEPENDENCE, IOWA\*

By SAMUEL W. HAMILTON, M.D., NATIONAL COMMITTEE FOR MENTAL HYGIENE, NEW YORK, N. Y.

THE problem of the care of tuberculous patients in a hospital for mental diseases presents some complications that do not appear in the plans for the ordinary care of tuberculous patients who can be depended on, for the most part, to order their own conduct. It is customary for an ordinary tuberculosis hospital to build quarters for three groups, ambulant, semi-ambulant and bed-fast. Some such grouping can be made in mental hospitals but it is still more important (a) that provision be made for a small number of disturbed patients and (b) that there be a section where patients with a depressive and self-destructive tendency can constantly be under supervision.

Various compromises result from an effort to meet these conflicting demands. Some buildings house the relatively quiet patient, whatever the stage of his pulmonary process, and leave the most difficult patients in other parts of the hospital, where the same high degree of ventilation and exposure to sunshine has not been provided. Oftentimes the depressed tuberculous patient has to be kept among the disturbed, because only there can he receive close scrutiny. Then there are buildings where a single restless patient is permitted to annoy twenty quiet ones. The whole subject of planning buildings for the tuberculous insane will

principles, however, that have been published by the National Tuberculosis Association should be taken cognizance of by every architect who is planning such a building, and expert advice on the requirements of mental patients should be sought from available sources.

At the state hospital at Independence, Iowa, a building has recently been erected for tuberculous mental cases. Externally it is an attractive looking red brick structure with white trimmings, planned on simple lines, pleasing to the eye. The interior is of reinforced concrete construction; the building is fireproof, a thing for which the state is to be congratulated. The wisdom of the policy of erecting permanent buildings for tuberculous patients instead of the shacks, so popular even now in some quarters but so utterly out-of-date, is to be commended. The building is a two-story and basement structure.

### Entrances at Rear of Building

The topography of the site and the requirements for the orientation of such a building bring the natural approach at the rear, and here the entrances have been placed. The first and second floors are alike. The two stairways are separated only by the nurses' office and are entirely



Rear view of new tuberculosis pavilion, State Hospital, Independence, Ia., showing main entrance.

be discussed in an early number of *THE MODERN HOSPITAL*.

Under these conditions it is not surprising that a large number of buildings for tuberculous mental patients are only make-shifts. Certain prin-

\*The writer extends his thanks to Dr. R. A. Stewart, superintendent, Independence State Hospital, for courtesies offered during this survey; and to Mr. T. B. Kidner, institutional secretary, National Tuberculosis Association, for advice and aid.

symmetrical. The division of sexes will have to be by floors, as arrangement has not been made to separate the sexes in this building on the same level, and some additional construction will be necessary in order that a large part of the male ward may not be seen from the stairway used by the women. The nurses' office is a commodious



View of stairway showing corridor and washroom.

room and if the desk is placed at the point farthest from the window, casual observation of a great deal of the activities of the ward will be possible, but full central control cannot be obtained.

The centre of the building, in front of the nurses' office, has been devoted in part to a nurses' toilet and bath.

Still nearer the front is a clothes room, capacious and quite usable, though dark. One prefers to have the clothing of tuberculous patients exposed to sunlight, but if one must choose between the clothing and the patients, it is better that the patients occupy the space where they can benefit by the solar rays. In front of the clothes room is a large serving room with a sink, cupboard, and dumbwaiter. In the accompanying sketch this serving room has been marked "day room" since it will be the only free space available for patients to lounge.

#### Original Arrangement of Wings

The ends of the building are homologous and may be described in three longitudinal sections; a porch in front, a dormitory in the middle, and rooms at the rear. The porch is particularly light and could hardly have been better planned, except that the windows swing from the top, so that shades are ineffective and outsiders are able to view the interior.

Parallel with the porch is the dormitory, separated from it by an attractive series of arches, well proportioned, giving a distinctively Roman touch to the style. Since there are no doors or windows in these arches a query arises as to the purpose of such an arrangement; to this we will revert later. At the end of the dormitory toward the center of the building is a fireplace.

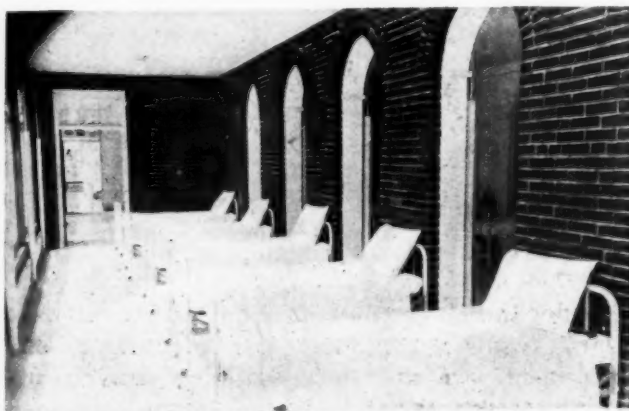
At the rear in the distant corner of the building is a lavatory with two basins, and behind this two toilets, so placed as to give a high degree of privacy. Then comes a corridor which is parallel with the dormitory and has two doors opening between. Along this corridor there are four rooms with outside windows on the rear

of the building. One is a bathroom with one tub and no shower. The next room was intended for a bedroom but will be devoted to the storage of linen. Next are two bedrooms eight feet four inches by eight feet ten inches, one of them being next to the stairway between the floors. Unfortunately they will have little sunlight. The corridor which connects these rooms with the lavatory is arched at both ends so that one looks through from the foot of the stairs into the washroom. These rooms are the only available places to care for disturbed patients and dying patients; it were better if their electric switches were in the corridor instead of in the rooms.

#### Maintenance of Temperature

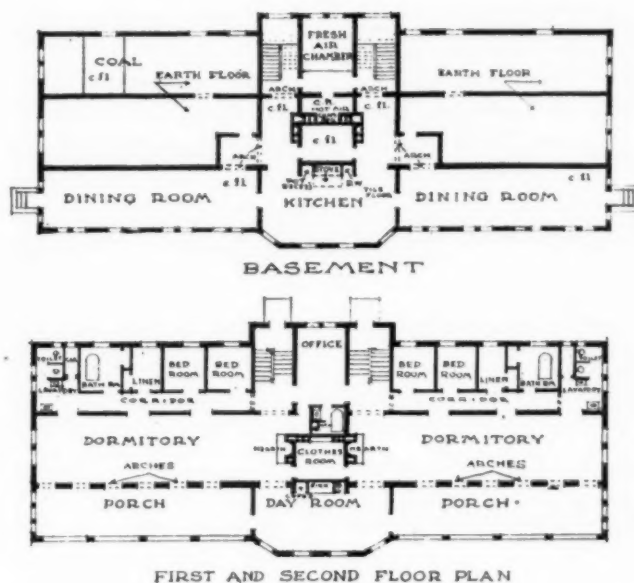
One hesitates to make an adverse criticism on a structure so outwardly attractive as this, yet it would be misleading to seem to commend the floor plan. It should be noted that the circulation of air by one route or another is unrestricted throughout the wards excepting in the single rooms at the rear, the nurses' baths and the clothes rooms. What does this involve? All these patients must be cared for in air of practically the same temperature at every moment. Let us assume that windows are open; then patients in the toilet, patients who are sitting up, the food that is being distributed to trays, are all in the same frigid atmosphere.

It is obvious that the care of all thirty patients cannot be at the same point of progress at every moment, and the patient receiving a bed bath ought not to be in zero temperature, although zero temperature may be a fine thing for another patient warmly wrapped up in bed. The space is too great to make it practicable to warm the whole floor three times a day for meals and have it cool between times. The inevitable result of such an arrangement is that the benefits of free ventilation will be only partially obtained, for windows are certain to be found closed. Some



Open air ward with view of dormitory through arches.





arrangement by which the patient could be bathed, dressed and fed in a warm room, then rolled out in his bed on to the porch would have increased the therapeutic value of this attractive pavilion by 200 per cent. Modern tuberculosis sanatorium practice is to provide the tuberculosis patient with a cool porch as his sleeping place, and with a room in the rear for his bathing, his feeding and the warming of his bed in frigid weather.

The kitchen is in the basement, and like other kitchens constructed in Iowa state institutions in recent years, has a ceiling nine feet high. It will thus be cruelly hot at certain seasons. The stove has to stand out in the room because the recess is too short for it, and the vacant space behind it will be hard to keep clean. Off the kitchen on each side is a dining room for ambulant patients. This is not especially attractive, but will serve the purpose. There is plenty of space for storage of coal and other supplies. Food stores will reach the kitchen from the main entrance at the rear, by what seems to be a complicated route down several stairs and through a series of arches, or they will be brought in through the dining room. Neither arrangement is convenient and something handier might have been provided.

#### Details of Equipment

The floors in the wards are of terrazzo which is pleasing to look at and easy to clean. It is not particularly easy on the feet of either patient or nurse, but perhaps rugs or rubber carpeting will relieve this to some extent. The floor of the kitchen is of red quarry tile which should prove quite satisfactory. Dining rooms and store rooms have concrete floors. Wash basins are set higher than usual, to the great advantage of the patients

who must use them. Radiator guards had not arrived when the writer saw this building. Window guards were to be installed throughout the building—the penalty one pays for not planning in advance for a small group of restless patients; the rest of the patients do very well without guards. Piping is everywhere exposed, a thing which we tolerate in factories and offices but which we should not be compelled to accept in hospitals. The walls of the toilet sections are tiled five feet up from the floor. The two hoppers are separated by a metal slab, and the floor has a suitable drain. As this room is cramped, its supervision will be somewhat difficult.

Strange to say, there is no shower bath in the building. It will probably be necessary to install one in the basement.

It may be repeated that this is a very pleasant, attractive little building. Some unfortunate errors have been made in the floor plan, so that it will be very difficult or impossible to keep the different parts of the ward at different temperatures. Separation of the sexes will require special supervision whenever the stairways are used. The kitchen ceiling is too low. Most unfortunate of all, there is not suitable provision for the disturbed. It will, however, be easy to keep the building clean. This cheerful environment will encourage the patients to view their lives hopefully and to accept the direction of those responsible for their sanitary welfare.

#### QUALIFICATIONS FOR OFFICE OF SISTER AT FAVERSHAM INFIRMARY

Qualifications for the office of Sister at the Faversham Infirmary, Faversham, England, as presented in a current issue of the *Hospital and Health Review*, are of interest in contrast to the qualifications for similar service in American institutions. The notice reads in part:

The Guardians require the services of a Sister for the male side of their infirmary.

Salary, £70 per annum, rising £1 annually to £75, with £3 in lieu of beer, with usual residential allowances and use of indoor uniform. The present infirmary staff consists of one Sister and six assistant nurses. Number of beds 100 (male and female).

Candidates must hold certificate for three years' general training in medical and surgical training in an infirmary maintaining a resident physician, and also be a holder of the C.M.B. Certificate.

Forms of application may be obtained from the matron, who is superintendent nurse, The Infirmary, Faversham, to whom the forms duly filled in with copies of three recent testimonials and certificates should be sent.

The appointment will be subject to the provisions of the Poor Law Officers' Superannuation Act, 1896, and the approval of the Ministry of Health.

By Order, Guy Tassell, Clerk, Union Offices, Faversham.



## The MODERN HOSPITAL

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- LULU G. GRAVES, *New York, N. Y.*  
Mt. Sinai Hospital, New York, N. Y.
- CAROLYN E. GRAY, M.A., *Cleveland, Ohio.*  
Western Reserve University, Cleveland, Ohio.
- C. FLOYD HAVILAND, M. D., *Albany, N. Y.*  
State Hospital Commission, Albany, N. Y.
- A. K. HAYWOOD, M.D., *Montreal, Quebec.*  
Montreal Gen. Hospital, Montreal, Quebec.
- LIEUT. COL. JAMES M. PHALEN, *Washington, D. C.*  
Medical Corps, U. S. Army, Washington, D. C.
- F. C. SMITH, M.D., *Washington, D. C.*  
Chief of the Hospital Division, U. S. Public Health Service, Washington, D. C.
- E. S. MCSWEENEY, M.D., *New York, N. Y.*  
American Sanatorium Association, New York, N. Y.
- C. W. MUNGER, M.D., *East View, N. Y.*  
Grasslands Hospital, East View, N. Y.
- W. G. NEALLY, M.D., *Brooklyn, N. Y.*  
Brooklyn Hospital, Brooklyn, N. Y.
- WILLARD C. RAPPLEYE, M.D., *New Haven, Conn.*  
New Haven Hospital, New Haven, Conn.
- LEWIS A. SEXTON, M.D., *Hartford, Conn.*  
Hartford Hospital, Hartford, Conn.
- GEORGE F. STEPHENS, M.D., *Winnipeg, Man.*  
Winnipeg General Hospital, Winnipeg, Man.

### "MY PLEDGE AND CREED"

THE corner stone of civilization is the sacredness of the body of man. This concept has its highest expression in those sciences which have for their object the preservation and restoration of health. The profession of medicine has crystalized its ideals in the ancient but ever-young oath of Hippocrates. It is equally fitting that the hospital field should sublimate the tenets of its faith and present them to the world in concrete form.

The editors of THE MODERN HOSPITAL have counseled with leaders of thought in the hospital and nursing professions and after many months of painstaking endeavor present in this issue "My Pledge and Creed."

This is at once a code of ethics, an exposition of the spirit which should and does activate those who consecrate themselves to the service of the sick and to safe-guarding the health of the human race, and a promise of steadfast adherence to those principles which are our guide in this work. The decorative treatment, both as to design and color, is adapted from the restoration of the Temple of Æsculapius at Epidaurus described in an article on page 199 of this issue.

It is hoped that "My Pledge and Creed" will meet with cordial approval and that hospital organizations will adopt it for their entire personnel. Aside from the fact that it is artistically presented, and hence has a decided ornamental value, it is believed that the daily contemplation of these basic truths thus beautifully expressed will be a stimulus to more kindly, more conscientious labor and an added realization of the dignity and nobility of the care of the physically and mentally ill. Society has created a carefully integrated organization for the accomplishment of this task and so intimately does it intermesh that the fireman in the boiler-room, the cook in the kitchen, the nurse at the bedside and the surgeon in the operating room are the mutually interdependent agencies upon whose minds and souls and bodies may depend the welfare of the patient. It is essential that they and every other person who bears even a remote relationship to those whose well-being is entrusted to a hospital shall be imbued with the high ideal of hospital service and to this end it is recommended that copies of "My Pledge and Creed" suitable for framing shall be placed in the hands of every such person, regardless of the position he or she may occupy in the organization.

The display of the articles of our faith is bound to have a good effect on the public from which hospitals draw their patients and their support.



The open acknowledgement of our conception of the responsibilities and ideals of our profession will increase the esteem and confidence in which our calling is held by the community.\*

### THE PATIENT GOES HOME

NOT a little has been written on the wisdom of the hospital's making a good impression on the patient when he first enters its portals. We realize the fact that first impressions are crucial ones in their effect both upon the patient and upon the hospital. The patient is pleased with the bright, cordial at-your-service way in which he is received, if he is given the little attentions which help him make the necessary adjustments to his new, and often difficult, circumstances. If received in this friendly manner, he gains a favorable impression that will tinge his attitude during his entire stay and soften, if not ward off, that criticism of the hospital which later circumstances might justify. From the patient's standpoint, the kindly character of his initial reception may have much to do with inspiring his faith in the institution and in the ability of its medical staff to restore him to health.

More should be said of the value to the hospital of the favorable impression it has an opportunity to make upon the patient's "discharge."

Then it is that the patient generally goes home improved in health and frequently cured. He goes with a new, sober outlook, with hope and gladness. He cherishes a feeling of gratitude to the hospital and to those who have ministered to him in his illness. Shall this fine feeling be shattered by the hospital's tactless, indifferent attitude at the time of the patient's home-going. Heaven forbid! Rather should the hospital take this opportunity to bid the departing guest a heartfelt adieu, and express its pleasure at having had the opportunity to serve him, and its hope that he will continue in good health. Thus will the hospital add to the strength of the bonds that bind the patient to it in loyalty and gratitude.

\*As a service to hospitals, the publishers have arranged with the Faithorn Company, 500 Sherman Street, Chicago, Ill., to supply copies of "My Pledge and Creed" in two sizes on heavy cardboard, at cost. The small size, similar to the copy presented in this issue, may be had at the following prices:

5 or less copies	\$0.10 each
6 to 10 copies	.08 each
10 to 25 copies	.07 each
More than 25 copies	.05 each

The large size, which is twice as large as the copy presented in this issue, will be sold at fifty cents each, and where more than one copy is desired, may be had at twenty-five cents each.

### ASSISTING THE HOSPITAL PATIENT OF MODERATE MEANS

WHATEVER the reasons, our readers are well aware of the steadily rising cost of hospital care during the past decade, a tendency which gives no present indication of abating. This increasing cost has laid a heavy hand upon those who cannot afford to pay the full cost of this service. How may this heavy hand be lifted or made to rest more lightly upon this group of patients? How may hospital care be furnished more economically, adequately, and efficiently, to those who cannot afford to pay the full cost of this service?

As people of moderate means make up the great bulk of our citizens, this is an extremely important problem and deserves most painstaking consideration. Our purpose here is not to indicate how this may be done most effectively, but rather to name the factors involved, in order that the subject may be more intelligently considered. The cost of hospital care includes three factors: the cost of domiciliary care, the cost of medical diagnosis and treatment, and the cost of nursing.

This subject was discussed very ably by Dr. George B. Somers, director of Lane and Stanford University Hospitals, at the third annual conference of the Hospitals of California, held October 18, 19 and 20, 1923. So far as the cost of medical service goes, it is Dr. Somers' opinion that low-cost medical service may be provided in a business-like way and yet along strictly ethical lines and without involving socialized medicine in the solution. For him, the answer lies in organization. To be more specific, the nucleus of the solution may be found in the diagnostic group already in existence here and there.

As regards the cost of nursing service, Dr. Somers believes that here too the solution, or a partial solution, lies in the device of organized groups of graduated nurses, who care for several patients through a period of hours.

As regards domiciliary costs, the problem of reducing these costs is an administrative one and calls for close vigilance with a constant study of operating items.

Whether the practical application of all of these measures on a broad scale will reduce the cost of hospital care to a point where people of moderate means can meet it wholly has not been conclusively demonstrated. The probability is that, even with the application of all of these measures, the hospital will still have to depend on endowments or on some form of aid from the community, be it in the form of individual con-

tributions, grants from community chests, or municipal aid.

The consideration of this important phase of the general subject of the conservation of public health stimulated the liveliest discussion at the California conference, developed so many angles and revealed such a wide diversity of opinions and plans that the conference requested the League for the Conservation of Public Health to investigate the question thoroughly and present its suggestions at the 1924 hospital conference.

As a slight contribution to the discussion of this subject, THE MODERN HOSPITAL has asked a number of its readers to express their opinions on the subject. Some of these opinions will be found on page 241 of this issue, under the caption "What Provision Can Hospitals Make for Patients of Moderate Means?"

### HOSPITALS IN OUR PROGRAM OF NATIONAL DEFENSE

THE setting aside by President Coolidge of September 12, the anniversary of the Battle of St. Mihiel, as National Defense Day, led us to ask the Surgeon General of the Army to prepare an article for our readers on hospitals as a factor in the medical program of national defense. (See page 206.)

In this article the Surgeon General outlines the character of the hospitals participating in the program, how they are organized, and when they may be called upon to serve.

As Surgeon General Ireland observes, the propriety of having a representative of the local hospital talent prepared to go with the men who must leave their community in defense of the nation in the event of war is apparent. Hence, since the termination of the World War, there has been established, in keeping with our program of national defense, a system of military reserve hospitals throughout the country. The framework of some 170 hospitals has been constructed and will be kept in a potential state of organization under military jurisdiction, to serve as reserve units of general, evacuation, or surgical hospitals.

The establishment of these reserve hospital organizations, prepared to branch off as the nuclei of military hospitals in case of war, gives evidence of commendable foresight, as does also the hospital organizations held in reserve for service in cooperation with the American Red Cross in the event of great calamity whether by earthquake, flood, or fire.

But while some 170 reserve hospitals have now been organized, there are still a number of hos-

pital units to be organized in order to meet the medical requirements of the six field armies which constitute the basis of preparation under the national defense program. We second the hope of the Surgeon General that every qualified institution will ultimately accept its part in this national project.

### A NOTE OF WARNING

In the June issue of THE MODERN HOSPITAL, page 586, Anna L. Gibson of Boston advocates the sterilization of knives and other sharp edged instruments by heating in liquid petrolatum.

Attention should be called to the fact that an open gas flame is advocated for this heating. It seems to us that the fire hazard in this procedure is a very great one. The chief of the technical department of one of the larger oil companies, when asked to comment upon this practice, stated that if the procedure were handled very carefully the fire hazard could probably be reduced to within safe limits, but that the danger incidental to heating a petroleum product over an open flame was such that he would not care to make any definite recommendation relative to its use in that way.

"Careful handling" can mean nothing else than continuous attention. It is a well-known fact that the varying duties of operating room nurses are such that it is a most difficult, if not impossible, thing to be sure that their continuous attendance could be guaranteed throughout the sterilization process. If the flame is left for any appreciable length of time, there is a very strong possibility of the oil boiling over with the resultant fire possibilities. As the sterilization would, in all probability, take place in the operating room department where ether and other inflammable substances are kept, it can be seen that the danger is a very great one.

If sterilization of cutting instruments in oil at a comparatively low temperature is satisfactory, it seems to us that an electric heating unit or the water bath method should be substituted for an open gas flame.

### STATE AID FOR COUNTY HEALTH WORK IN NEW YORK

One county out of the sixteen in the state of New York which have taken advantage of the funds for state aid for county health work is applying the fund toward the establishment and equipment of a rural general hospital. The other counties are using the fund in the following ways: ten are applying it to establishing nursing service; three for nursing and clinic service; one to establishing a board of public health, and one to establishing a dental clinic.



## REGISTRATION FOR PRIZE ESSAY COMPETITION CLOSES SEPTEMBER 15

**W**IDESPREAD interest in THE MODERN HOSPITAL'S prize essay competition on "The Interrelationships of Hospital and Community," has been evidenced during the past month with indication that the remaining two weeks will bring a larger number of contestants. More than 100 individuals representing communities from New York to California have expressed interest, and many of these have already signified their intention of entering the competition.

If the number of inquiries and comments is an indication of interest in the problem of hospital and community relationships, we must accord the East first rank in its signs of progress, for the largest number of responses have come from eastern states, with New York in the lead. The people of the western states are also alive to the problem of community interests, as is shown by the large number of Californians and representatives of other western states, who have made inquiries and shown interest in the competition. That interest is not confined to sections of the country, or even to the United States itself, is evidenced from inquiries from abroad and the registration of one British and one Canadian hospital superintendent.

### Interest Springs from Many Fields

Interest in the competition is by no means confined to hospital executives. A large number of public health officers, social service workers, directors of community chests and community councils, national and local health agencies have displayed interest. These people are not only interested individually but collectively as well, as is shown in one eastern city where a community council is working on the essay as a group study.

The timeliness of the essay and the need for centering attention on this problem as well as the benefits which may come from the ideas which the competition should bring forth are assured by the general commendation of leaders in the hospital and public health fields who are sponsoring the competition and influencing others to direct their attention to the problem.

Dr. Haven Emerson, professor of public health administration, Columbia University, New York, N. Y., chairman of the committee of award, believes that the contest will be valuable in directing attention to the larger aspects of the hospital as the logical place for the health center of the community as well as the center of diagnosis and cure of disease.

Dr. Willard C. Rappleye, superintendent, New Haven Hospital, New Haven, Conn., member of the committee of award, makes this comment on the essay competition: "Nothing but good can come from the healthy discussion the essay competition will raise on the question of hospital and community relationships."

### Extension of Hospital Service

That the competition should promote the extension of hospital service in the community is brought out by Dr. Frank Billings, retired president, American Conference on Hospital Service, Chicago, Ill., who says, "Such discussion as the contest will bring forth should help advance the needed extension of the services of hospital to community as an extra-mural service."

The value of the contest from the standpoint of re-

search is emphasized by Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, who comments thus: "The contest should uncover some new ideas to consider and also may reveal a number of individuals whom we do not know who have a real conception of community hospital service and function."

Dr. Ernest P. Boas, medical director, Montefiore Hospital for Chronic Diseases, New York, N. Y., comments on the contest in the following remarks: "It strikes me that the plan for the prize essay contest for the discussion of the interrelationships of the hospital and the community is a good one. There is certainly need for a crystallization of opinion on this point and I am sure that a plan such as yours will greatly contribute to this end."

### Help Hospitals to Formulate Policy

Dr. Nathaniel Faxon, director, Strong Memorial Hospital, Rochester, N. Y., believes that the competition is a factor in guiding hospitals in formulating a definite policy. He says in regard to the competition: "I believe that the subject is one of great interest and that the essay competition is distinctly worthwhile. I believe that it is an excellent idea in the way of having the hospital take a mental account of stock, as to what its policy has been, is, and will be, in relation to the community. It will tend to bring out a more intelligent and progressive policy for hospitals to follow."

Dr. C. W. Munger, medical director, Grasslands Hospital, Valhalla, N. Y., says: "The plan of the prize essay competition is capable of creating considerable interest in an important matter, for the most part, neglected by our institutions. I believe that the publication of a group of essays on this subject will materially help to remind hospital administrators of a duty which they have often neglected."

### The Contest and the Small Hospital

The importance of the contest from the standpoint of the small hospital is commented on by Dr. Willis G. Neally, director, the Brooklyn Hospital, Brooklyn, N. Y., who says: "I think that the competition should arouse considerable interest among small hospitals in small cities where community relationship is marked."

Dr. Charles J. Hastings, medical officer of health, Toronto, Can., makes the following comment on the competition: "I think that the prize essay competition is very advisable and should result in much good both to hospitals and the communities. Hospitals have some things to learn in the way of constituting themselves a health center, inasmuch as by doing so, they would be rendering a greater service and be much more popular as far as the public sentiment is concerned."

With the approval and sponsorship of leaders in the hospital and public health fields, THE MODERN HOSPITAL expects that during the remaining two weeks left to register there will be a goodly number of recruits to enter the competition. For the benefit of those who have not yet registered, we remind prospective contestants that September 15 is the closing date of registration and that all essays are to be in the hands of the Contest Editor, 22 E. Ontario Street, Chicago, Ill., not later than November 1, 1924.

## VETERANS AMONG OUR TRUSTEES\*

**T**HE Staten Island Hospital, Staten Island, N. Y., claims the distinction of having the trustee in long-est service in the hospital administrative field in America.

Mr. Edward Clark Bridgman was born in Charleston, S. C., October 28, 1849. His family moved to Staten Island, in 1857, Mr. Bridgman being then a boy of eight years. Since that time he has been not only a continuous resident of Staten Island but an active participant in many of its organizations and enterprises. As he himself says, he does not know what to be the most proud of, his forty years as a trustee of The Staten Island Savings Bank, the last twelve of which he has served as its president; his connection with the Presbyterian church of his community in which he has been an active member since his primary class days, a member of the session for forty-six years and superintendent of the Sunday school for thirty-five years; his forty-seven years as the head of a map and chart publishing company, inherited from his father or, his forty seven years as a member of the board of trustees of The Staten Island Hospital.

Mr. Bridgman was elected to the hospital board in the spring of 1877. He was made secretary of the board the same year of his election and so served until 1905. From 1901 to 1903 he also served as vice-president of the board.

In 1887, when a bequest made by the late Dr. George W. Frost in memory of his "old friend, Dr. Samuel R. Smith" made possible the building of what is now the central unit of the hospital group. Mr. Bridgman was appointed chairman of the building committee and was actively connected with the building activities from "the ground to the ridge-pole, on which he sat at its completion." On the completion of the building he headed the committee on house, grounds and building and, as head, gave freely of his time for over thirty years.

Among his other activities was that of publicity agent, carrying on an extensive correspondence and, as he says, giving more time to the institution than to his own business.

Mr. Bridgman has known personally every president of the board of trustees since its formation in 1861 and a large percentage of all those otherwise connected with the institution, either as officers, trustees, members of the women's auxiliary or nurses.

During a period of disquiet on the part of the attending staff during the years 1892-93, Mr. Bridgman was the principle figure in bringing about a settlement of the trouble and accomplished this in such a way that Dr. Craig, then a member of the state board of charities, was enabled, upon investigation, to give the institution a high rating of efficiency in every respect, which rating has been maintained ever since.

Mr. Bridgman still retains an active membership on the board of trustees. His presence at the monthly meetings is considered an inspiration and his advice and suggestions are much sought after and approved. To the members of the administrative staff too, is he "an ever present help in the time of trouble."

### HOW ST. JOSEPH'S HOSPITAL, LORAIN, OHIO, CARED FOR TORNADO VICTIMS

What can be accomplished by a modern hospital suddenly demodernized by a devastating tornado was shown in the rôle played by St. Joseph's Hospital, Lorain, Ohio, in the emergency care of the victims of the tornado, June 28.

Although the hospital is situated just outside of the devastated territory it was the nearest place of refuge, and within a few hours after the storm 500 victims were brought to the hospital. One hundred twenty-five of these became overnight patients. The large number of emergency cases to be housed and cared for necessitated tripling the capacity of cots and mattresses placed in the basement and corridors.

As gas and electricity and telephone service were shut off, the hospital was handicapped in all emergency work. Patients had to be carried from floor to floor by hand on stretchers and undertakers' baskets. Major operations and x-ray work had to be done by the light of candles, flashlights and spotlights attached to dry batteries, and water had to be heated on a lone combination range.

At the time when the first victims arrived there was but one doctor and an intern in the hospital in addition to the staff of twelve sisters and about thirty nurses. After several hours medical and nursing aid was procured from Elyria and Cleveland. The feats which were accomplished in caring for victims were made possible largely through assistance from the Red Cross and from soldiers and Boy Scouts who ran errands.



Mr. Edward Clark Bridgman

\*This is the fourth of a series of sketches of hospital trustees who have given long and faithful service. Contributions to the series will be welcome from hospitals where trustees have served for twenty or more years.



## A CLINIC ON HOSPITAL REPORTS\*

WITH this issue of THE MODERN HOSPITAL the clinic on hospital reports, which began in March this year, ceases. From such comment on the clinic reports as has been received from hospital superintendents and others, it appears that there is among them a general recognition of the inadequacy of hospital reports, and an earnest desire to make them a more useful medium of publicity. With more than a billion dollars being spent annually in the construction, equipment and maintenance of over 7,000 American hospitals, the problem of developing more satisfactory hospital and community cooperation is rightly regarded by hospital administrators as of major importance.

That the hospital ought to be a more effective agency for public health and social welfare—not merely a curative but a preventive service—is a new thought to most people, and one that requires, on the part of the hospital, a thoroughgoing community educational program. The director of the clinic, Dr. Carl E. McCombs of the New York Bureau of Municipal Research, regards it as highly significant that there was a close correlation between the interest and value of the reports reviewed by him and the extent to which the various hospitals had extended their general community contacts—particularly in the field of hospital social service.

In this clinic two more hospital reports are briefly reviewed, following which Dr. McCombs presents in summary form the major defects of the many hospital reports which have been discussed during the course of the clinic, and offers some suggestions on hospital report writing.

*Case No. 13 (A General Hospital).*

This report of a small general hospital in a central New York village is a compact, pocket size number of only thirty-two pages, of which eight are devoted to well-selected pictures. After wading through a half dozen reports of from 100 to 150 pages, a little pamphlet like this is most cordially welcomed. The secret of its brevity and effectiveness is that instead of its being a mere collection of the reports of several department heads, the report is almost exclusively the work of a superintendent who knew what to say and said it. Of the twenty-four pages of printed matter, the superintendent uses twelve for a complete but succinct statement of the exact financial condition of the hospital, the nature and extent of its service for in-patients and out-patients, changes in personnel, a summary of operations of the various departments, repairs and improvements during the year and recommendations for further extensions of service. It is an admirable statement and is supported by a well-organized body of financial and other statistics. The report has unity, balance and the evident intent to give the community a clear cut picture of the hospital's business and quality of service.

**Compilation Method Not Unified**

The lack of unity in hospital reports generally is, in the judgment of the examiner, due in the main to the compilation method of preparing them. It is, of course, far easier for a superintendent to accept the reports of department heads, add a brief comment in his own hand and bind the whole together as the hospital report. But the best reports examined during the course of the clinic

have been those which have been written by the superintendents themselves. They are almost invariably more logical in presentation, there is less duplication of material, greater brevity and clarity of statement, and technical details of hospital operation are not over-emphasized. Hospital reports will be greatly improved when hospital superintendents recognize their own responsibility for report writing. If the hospital superintendent will take the reports of his department heads, review them carefully, eliminate non-essential matter, summarize what is left and write a brief non-technical digest of the whole story with such statistical support as may be necessary, he will not only save money, but will produce a much improved document.

*Case No. 14 (A General Hospital).*

As a contrast to the report just reviewed, this report of a hospital of about 250 beds in a large eastern city is interesting. The report covers the nine months ending June 30, 1922, and the year ending June 30, 1923, and comprises 137 closely written pages without any illustrations. It is a compilation report—that is to say, it is made up of a large number of reports of department heads.

**Duplication of Department Reports**

Since the report covers part of one fiscal year and the whole of the succeeding one, the volume contains two directors' reports, two superintendent's reports, and two reports of each department chief including the dispensary and the departments of gynecology and obstetrics, surgery, medicine, pediatrics, radiology, pathology and bacteriology, social service and training schools. There are also two complete financial statements and two statistical summaries of patient service. The result is not only an unnecessarily extended report and consequent increased cost, but an almost complete lack of report unity. Assuming that the reader is persistent enough to finish the report, when he completes it he has only a confused impression of the hospital, not as a unified and integrated hospital organization and service, but rather as an assemblage of more or less unrelated departments.

The size of this report could have been reduced at least by one-half had the material been better organized. All statistical summaries might have been consolidated for the two periods included. Similarly the reports of the various department heads might well have been consolidated in summary form for the two fiscal periods. The suggestion previously made that hospital reports should be written by the superintendent instead of being a mere compilation of reports of department heads, if it had been applied in this case would have materially improved the report.

If the superintendent had taken these departmental reports, eliminated all duplication and non-essential matter, brought out in logical sequence and under appropriate heading the significant matter on hospital organization, finance, equipment, service and needs, the only loss would have been in bulk. It is proper, of course, to give due recognition to the heads of the various hospital departments, but this can be done by reference in the superintendent's summary report.

**A Summary of Hospital Report Defects**

As observed during the course of these clinics, the major defects of hospital reports, at least from the

\*This is the last of the series of clinics on hospital reports conducted by Dr. Carl E. McCombs, for THE MODERN HOSPITAL.

examiner's point of view, are:

(1) They are in the majority of instances too long, mainly because they are of the compilation type in which the heads of hospital departments are permitted to develop their report material as they choose.

(2) Many are unattractive in appearance because of poor selection of cover color or cover material or because badly typed. In long reports the lack of good pictures is also a conspicuous defect.

(3) Few reports are well edited. There is apparently little attention given to planning the report to eliminate duplication, consolidate statistical summaries where possible, compel logical sequence in presentation, or bring out in relief the most significant facts about the service.

(4) Few reports show a recognition on the part of their makers of the hospital's place in the community health and welfare program. Many reports, because of the lack of standard nomenclature of disease and injury, present no statistics whatever that can be used in determining the health status of the community.

(5) Information on the kind of service available to citizens, how it may be best utilized by them and what it costs is frequently omitted.

(6) Statistical tables covering finances or patient service are not, in the majority of instances, adjusted to conform to the standards recommended by the committee of the American Hospital Association and are, therefore, not comparable.

#### Some Suggestions on Hospital Reports

The director of the clinic has never prepared an annual report of a hospital. He recognizes, therefore, his own incompetence to direct others in hospital report writing. But such experience as he has had in writing reports on other phases of public service has established to his own satisfaction, at least, the need of observing certain basic principles of reporting.

The first principle is that a report should first be prepared in outline and the subject headings so arranged in logical sequence as to lead the reader to form for himself the conclusions which the facts make inevitable or to endorse the conclusions set forth by the report writer as an interpretation of the facts.

The second principle is that a report which deals with a functional entity should be written by one person who has in view the whole picture of the service dealt with. That is to say, the compilation method of preparing a report which includes a large number of independently written statements by different persons having different perspectives rarely produces satisfactory results.

The third principle is that the report maker should keep in mind at all times the composition and character of the group or groups which he proposes to interest, inform and influence. If a report is prepared for a group of professional workers familiar in the main with the elements of the service examined, much can be eliminated or briefed that should be set forth in more detail and in a less formal manner when the report is intended for the review of the general public.

#### Skeleton Outline of Report Material

With these three principles in mind, the director of the clinic ventures to suggest an outline of hospital report content. Standardization of hospital reports is not aimed at, only such material should be standardized as is needed for purposes of comparison.

(1) A statement of what the hospital's purpose and program is,—that is to say, what those responsible for

hospital administration regard as its proper sphere of service. This statement might well include a summary of the history of the hospital's development.

(2) A statement showing how the hospital is organized and equipped for public service and, if it is not adequately organized and equipped for its purposes, what more it needs.

(3) A statement showing how the hospital is financed and how it spends its money, what it owns and owes, and what additional funds it needs to carry out its desired program.

(4) A statement of the numbers and other facts about patients cared for, their diseases and injuries, and what was done for them. Typical case "problems" and their solution through medical or surgical care, social service relief, etc., might well be used for purposes of illustration. The importance of efficient hospital service in the promotion of community health and welfare should be clearly brought out.

(5) A statement telling citizens how the hospital's service may be best used, how to be admitted, what charges are made, something about the dietary, the rules governing patients' conduct, visiting, etc. If wider citizen cooperation is wanted, the citizen should also be told how he can help financially and otherwise.

(6) An acknowledgment of special service rendered the hospital by professional or lay individuals or groups.

#### C. H. A. MARITIME CONFERENCE MEETS AT CHARLOTTETOWN

The annual convention of the Maritime Conference of the Catholic Hospital Association was held on July 9, 10 and 11 in the assembly hall of Notre Dame Academy, Charlottetown, Prince Edward Island. The conference was attended by representatives of the different Catholic hospitals of the maritime provinces. Many interesting and instructive papers on hospital work were read, which gave rise to practical discussions on the different subjects.

The members of the conference also had the privilege of attending one afternoon session of the branch meeting of the American College of Surgeons and of having two special conferences given them by Dr. Malcolm T. MacEachern, president, American Hospital Association.

At the last session of the conference the following officers were elected for the coming year: president, Sister Carroll, R.N., Hotel-Dieu Hospital, Campbellton, N. B.; first vice-president, Sister M. Gertrude, St. John Infirmary, St. John, N. B.; second vice-president, Sister Marie of Perpetual Help, R.N., St. Martha's Hospital, Antigonish, N. S.; secretary-treasurer, Sister Kerr, R.N., Hotel-Dieu Hospital, Campbellton, N. B.

#### COMPETITION FOR BEST ORTHOPEDIC WORK TO CLOSE DECEMBER 31

Announcement has come of a competition for the best recent orthopedic work or invention, offered by the Rizzoli Institute in Bologna, Italy. The competition is open to Italian and foreign doctors and the award for the winner is 3,500 lire.

The competition closes December 31, 1924. The regulations of the contest may be obtained from G. Pini, president, Rizzoli Institute.

Holes in the street are warnings against more holes. So are holes in the graveyard. Repairs in time will delay both.



## WHAT PROVISION CAN HOSPITALS MAKE FOR PATIENTS OF MODERATE MEANS?

RECENT conferences of hospital executives have given much time and discussion to the problem of hospital care of people of moderate means. The subject is one that is vital and is growing more important as our population increases. The statement is often made that the very poor and the very rich can receive every care at the hands of the hospital, but that the man of moderate means is unable to avail himself of hospital care.

At any rate this phase of hospitalization is a distinct problem and worthy of the consideration of the entire hospital field. It seems as if the time had come for a better understanding of this matter between the public and hospitals. If hospitals are unable to relieve the situation by measures which will lighten the burden of the patient then it is their duty to instruct the public as to what is expected of the patient.

Opinions of hospital executives on this matter vary widely, from those who extend undue lenience to patients to those who have no sympathy with the patient of moderate means. The opinions of four hospital executives of experience from different sections of the country are given as representative expression from leaders in the hospital field.

Mr. Michael M. Davis, Jr., executive secretary, committee on dispensary development, United Hospital Fund, New York, N. Y., makes the following comment:

"How big is the problem suggested by this title? Who are 'persons of moderate means?' Do we mean persons who pay United States income taxes but no surtaxes? If so, then the problem of 'adequate care for persons of moderate means' is a problem of only ten per cent of the population.

### The Situation in New York

"Or do we mean the people who are self-supporting, but have only a small margin of income above the expenditures necessary for a minimum of comfort? At the Cornell Pay Clinic, New York, N. Y., which aims to provide care for self-supporting persons of moderate means, a social-economic study of many patients has been made, leading to the following conclusion:

"The characteristic Cornell patient is the head of a family of two or three members with an income of about \$150 a month. If the income is more than this amount the family is generally of considerable size and some of the children have entered industrial life. In the larger families where there is more than one wage earner there are usually young mouths to feed and aged parents to make comfortable. It is evident that in most families there is considerable deprivation in time of illness and that ability to pay for medical care is distinctly limited."

"The most recent authoritative estimate is that more than two-thirds of all families in New York City have incomes of less than \$2,500 a year, not quite a fourth have incomes of from \$2,500 to \$5,000, and less than a tenth have incomes above \$5,000. Proportions in smaller places would be a little less for the higher levels and a little more for the middle levels. Studies of family budgets have led to estimates that, for a family of five with an income of \$2,000 or so per year, sixty dollars might be allowed for the care of health, that is, doctors' fees, medicines, nursery and dentistry. If much more than this is expended, a family must pinch in food, clothing, hous-

ing, or some other necessity."

"How far would sixty dollars or even one hundred dollars pay for a single case of serious disease requiring hospital care? How far would it pay for the diagnosis in an ambulatory case of an obscure ailment, not to speak of care after the diagnosis is established?

"One two-week stay in a hospital at five dollars a day, without any fee to the physician, takes the year's allowance for this family of five. With a medical fee and the extra expenses usually attendant upon illness and convalescence, the family must take an additional hundred dollars or more from its budget for food, clothing, housing, or minor necessities. A few visits to the office of a specialist, with the laboratory tests and x-rays required to make a diagnosis—we will say of a possible gastric ulcer—would also take at private rates, our family's annual allowance for the care of the health of all of its members. Semi-annual cleanings of teeth for this family would cost forty dollars at city dental rates and this with an oculist's examination and a pair of eye glasses for one of the members would again take all the family's annual allowance, leaving nothing for acute illness.

"Why go further? The problem affects the larger part of our population. It affects some of the people all the time and nearly all of the people some of the time. That is obvious.

### Suggested Remedies

"More moderate priced beds in hospitals are proposed as one solution. Very well as far as this goes, but only a small proportion of disease is hospitalized. Pay clinics have been suggested as a solution. They would reach a wider field than the hospital, both in diagnosis and treatment. Health insurance has been suggested as a solution. Preventive medicine is helping to solve the problem in certain points, as, for instance, by wiping out typhoid as a hospital problem in most communities.

"There can be no one solution to a problem which is so large in bulk, affecting so many persons as possible patients, so many physicians, so many varied interests and institutions. It is clear that private medical practice must face adjustments if the problem is to be solved. It is clear that other necessary steps are a larger use of hospitals by persons of moderate means and a much larger development of clinics working at cost (including in cost remuneration for the physicians).

"The very magnitude of the problem lends a certain encouragement. The self-interest of the general public can be enlisted to aid in its solution. The public must come to look upon hospitals not as "charities" but as institutions for the practice of medicine, not displacing bedside care in the home but providing all the people and all qualified physicians with facilities for better diagnosis, treatment and prevention of disease which will render medical practice more efficient and more capable of reaching every one of those who need its benefits. In this great task of public and professional education a large share of responsibility falls upon the hospital world."

Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill., upholds the present state of hospitalization as follows:

"I cannot but feel that sympathy for the people of

moderate means is being somewhat overworked. The statement has frequently been made that the very rich and the very poor can receive every care at the hands of the hospital but that the man of moderate means finds hospital care beyond his ability to pay. In view of the constantly increasing cost of hospital care of patients the above statement might be true if the wages or salaries of people of moderate means were what they were a few years ago; but the person of moderate means today enjoys an income which, a few years ago, would have marked him as a man almost of affluence.

### Patients Have False Pride Complex

"The trouble with the man of moderate means today is that he is unwilling to accept moderate accommodations in the hospital. He wants, if not the best, nearly the best the hospital affords and is unwilling to lower his expenses by taking anything less. He may be justified in this because his income is now sufficient to meet such expense. When you consider that our artisans, such as brick layers, carpenters, plumbers, are receiving from a dollar to two dollars and a half an hour, a charge of four or six dollars a day for hospital care in a private room is not exorbitant. The hospital giving this care at the above rate would also provide all needed care in small or general wards at a much less rate; but the man of moderate means won't accept care in the cheaper quarters.

"Hospitals have to live, the same as other institutions. Those that are endowed use the income from their endowment for the care of their free patients and anyone paying his way in the hospital must expect to pay at least the actual cost to the hospital involved in his care.

### Uncompromising Attitude of Patients

"Not infrequently patients go to hospitals and plead inability to pay the standard rates of a hospital for the quarters they desire but refuse absolutely to take quarters within their ability to pay. Were such a patient to go into a clothing store and say he was shivering with cold because of no overcoat, the proprietor might be accused of lack of charity if he refused to give the man an overcoat that would protect him from the weather. But if the man demanded a fur-trimmed and fur-lined overcoat at a price less than the cost of the coat to the dealer and refused to accept any other coat, the dealer would scarcely be condemned as a man of no charity, because he did not comply with the wishes of the shivering purchaser. Yet this is practically what happens every day in our hospitals.

"No hospital will turn from its doors any man needing treatment and unable to pay for it. It does ask, however, that when the patient is able to pay, although not largely, he should keep his demands within his powers of payment. When this is done, there will be less talk about the poor man of moderate means being unable to get hospital care. Every hospital worthy of the name will do all it can to care for every patient who comes to it, but the hospital demands that the patient himself do something towards making the expense as low as possible."

Mr. J. B. Franklin, superintendent, Baylor Hospital, Dallas, Texas, offers the following suggestions:

"First, let us assume that hospitals are prepared to provide adequate care for the poor and the well-to-do. This being true, such hospitals are evidently organized and have abundant facilities and help. An organized hospital must have an organized medical staff. An organized and cooperating medical staff is able and willing to help

the hospital provide adequately, not only for the poor and the well-to-do, but also for the third and only other class, people of moderate means who do not want charity, and who cannot afford to pay large fees.

### What the Staff Can Do

"The staff can agree, by resolution, to base all fees on the ability of the patient to pay, and can agree to refer any disputed fee to a committee of the managing board of the hospital for arbitration. This, I think, will satisfy the public that charges will not be exorbitant, and only very rarely will a case ever be referred to the board for adjustment.

"And I believe there may be and should be such a spirit of loyalty, cooperation and willingness to serve, by and between all staff members, as to make it a practice, and even a rule, that one staff man may call in consultation any other fellow staff man at a very nominal cost, if not altogether on the basis of *pure reciprocity*, to the end that each and every patient, who cannot pay the usual charges, may have the full benefit of group opinion at a moderate cost.

"There should also be a different schedule of charges to this great middle class, or small salaried class, for x-ray service, considerably below the charges made against those who are well able to pay. And if the laboratory work is not done on a flat moderate fee basis, due consideration and allowance should be made in laboratory charges to this class.

"Group special nursing, permitting one nurse to care for several patients, may also be provided at a considerable saving to the individual patient.

"These various suggested considerations should be practiced in behalf of the patients who are willing to cooperate. The patients who demand expensive private rooms, and other things that go with such rooms, should pay regular charges, notwithstanding their limited financial ability. As a rule, only those who try to help themselves should be helped by others. False pride and pauperism should not be encouraged. No one should be encouraged in thinking the world owes him a living unless he does his part to earn it.

"With hospitals that are fortunate enough to have endowment funds or other means to care for any deficit, the problem of caring for patients of moderate means is not a difficult one; on the other hand, with hospitals that are entirely dependent upon their receipts for maintenance this takes an entirely different aspect. Such is the case with a large majority of hospitals in the South. The amount of charity done in these hospitals must necessarily be governed by their receipts. Therefore, any plan that directly affects receipts will have a very definite bearing on the amount of charity done.

### The Problem in the South

"The Baptist Memorial Hospital has a daily average of 250 patients. Last year's charity amounted to \$100,000, and so far this year, at the present rate, it will be increased about \$50,000 with no apparent increase in the number of pay-patients admitted. If anything, there will be a decline. So long as the present condition exists there is little to be done, to my mind, along these lines.

"We have, however, made a few changes, such as having a maximum laboratory rate for ward patients and have installed only recently cubicles in several wards at a daily rate of \$2.50. These changes have proven very satisfactory, so much so that at the present writing, we



are contemplating installing several others throughout the hospital.

"Conditions such as we have to confront here do not exist, I know, in other sections throughout the country, and I believe that this is a matter that depends entirely upon local situation and existing conditions in different localities.

"The situation in regard to this hospital has been brought about by the fact that the territory from which

we draw our patients, mainly from sections of Arkansas, Mississippi and Tennessee, has undergone the most serious financial setbacks in recent years, having had three consecutive crop failures. Added to this is the fact that there are continually being opened small hospitals of ten to twenty beds throughout these sections.

"All these things have reduced the number of patients of moderate means who find it very hard to pay hospital charges."

## COURT DEFINES PUBLIC CHARITY INSTITUTION IN SANTA ROSA CASE

BY DOROTHY KETCHAM, ANN ARBOR, MICH.

THE case of the *City of San Antonio v. Santa Rosa Infirmary 249 S W 498* was reported in THE MODERN HOSPITAL, July, 1923, p. 61 . . . . The court of civil appeals rendered a decision January 24, 1923, and two motions for rehearing were denied March 21, 1923. April 11, 1923, a writ of error was granted and the Commission of Appeals of Texas, section 4, rendered a decision March 12, 1924, reversing the judgment of the court of appeals and affirming that of the district court entering the same as the opinion of the supreme court.

This was originally a suit to recover taxes from the congregation of the Sisters of Charity of the Incarnate Word and the Santa Rosa Infirmary, both of which were incorporated under the laws of Texas. The Infirmary is a general hospital in the city of San Antonio for the treatment of surgical and medical cases, and liability for taxation was denied under the constitutional exemption. No jury was had in the trial court and the case was submitted on an agreement between the parties which pointed out, among other things, that "the sole question for determination in this cause is whether or not the institution owned by the defendants is exempt from taxation by reason of the constitution and the laws of the State of Texas; and, further, that the property in question has never been exempted from taxation by the governing body of the city of Antonio.

### Incorporated for Charitable Purposes

"It is also agreed that the city has not assessed any taxes on that part of the building used exclusively for religious purposes."

The technical points of law raised will not be reviewed here, but it may be well to consider some of the facts of the situation. The Sisters of Charity of the Incarnate Word, according to the court, were incorporated without capital stock under the laws of Texas in 1881 "for the purely charitable purpose of the adoption of orphans and other children and the caring for and nursing wounded, sick, and afflicted persons," and prior to March 1, 1919, in addition to conducting the hospital here under consideration, operated orphanages, a home for the aged, and several educational institutions at different locations in San Antonio, wholly distinct and segregated from the land upon which the hospital was located. *Other than in the conduct of the hospital* the activities of this corporation appear to have been of a purely charitable or educational character.

The hospital was chartered in 1918 for the purpose of administering to the sick, the infirm, the helpless, the maimed, and the afflicted of all creeds, colors, and na-

tionalities, etc. It was to be benevolent and charitable in character with the right to acquire and hold property and dispose of the same in the interests of the corporation. It had no capital stock and the members were chosen from the Sisters selected by the Superior. In the opinion of the court it is quite apparent that the hospital corporation, "as such, is merely subsidiary to the parent organization, and is controlled by it in the management and operation of the hospital property."

### Treated Both Pay and Non-Pay Patients

The details of testimony will not be recalled except for the finances. It was pointed out that no one is refused admission as a patient except those with contagious or mental disease. A charge is made to all patients whose financial conditions permits them to pay for the service, "the money so received is used for the maintenance, upkeep, and improvement of the hospital facilities, for the liquidation of debts . . .; also an assessment is paid to the mother house to maintain and educate the young sisters, future members of the Santa Rosa Infirmary Corporation, and for the support of the disabled members of the corporation. The infirmary has no other source of revenue than that derived from pay patients. The rate of charges for pay patients varies from \$12 to \$45 per week, according to accommodation required by the patient. A special charge is made for operations, laboratory facilities, medicines, medical supplies, and surgical dressings. The funds derived for the maintenance, upkeep, and improvement of the hospital facilities are derived solely from receipts from pay patients. In 1918 the receipts were \$117,767.55; in 1919 \$169,175.99; and in 1920 \$204,296.50. The disbursements for 1918 were \$94,365.57; for 1919, \$148,228.80; and in 1920, \$171,465.33. The funds so earned during these three years were paid out, first, for the maintenance of the infirmary, upkeep, and improved facilities, debt and interest, training of future members of the corporation, for the support of the aged and disabled members, and the balance to a building fund."

### Charity Clinic Maintained by Hospital

The Sister further testified concerning St. Luke's Clinic which is operated "to give eye, ear, nose, and throat treatment to poor patients" as an added expense to the hospital. The drug store was operated at a small profit only for the accommodation of patients and doctors. Concerning the pay of physicians, pay patients pay their own doctors separately. There is a staff of physicians *not* paid by the hospital who come when called. "The hospital

is open, or the operating room, to any doctor who wishes to operate there, or patients can select any doctor they wish to treat them in that hospital. The sum of \$3,800 was paid to the mother house for training young Sisters. It is estimated that during 1919, 2,027 patients were treated in St. Luke's Clinic as free or charity patients for eye, ear, nose and throat troubles. Two thousand nine hundred and nineteen patients were received in the hospital for other treatments of which 2,590 were full-pay patients, 123 part-pay patients and 206 charity cases. Five thousand three hundred and sixteen visits were made by Sisters to outside patients for which no charges were made, and 7,200 free meals furnished to indigent outsiders.

The court points out that while the charity patients were not sought out, they were received for care upon application and statement. The operation and control of the hospital were in the hands of the Sisters designated by the parent corporation, such Sisters serving without compensation other than meals, room, clothing, burial at death, etc.

The exemption of the property is claimed under the constitution, article 8, section 1. General law, article 7507, subdivision 6, relating to public charities which is too long to quote here but which exempts "all buildings belonging to institutions of purely public charity, together with the lands belonging to and occupied by such institution not leased or otherwise used with a view to profits, unless such rents and profits and all moneys and credits appropriated by such institutions solely to sustain such institutions and for the benefit of the sick and disabled members and their families and the burial of the same, or for the maintenance of persons when unable to provide for themselves, whether such persons are members of such institution or not. . . ."

#### Meets Two-fold Charitable Requirement

The constitutional requirement according to the court is twofold; the property must be *owned* by the organization claiming exemption and it must be used exclusively by the organization, as distinguished from a partial use by it and a partial use by others, whether the others pay rent or not. The court points out that both of these requirements are fulfilled" . . . but it is insisted that, because the major part of the rooms in the hospital was used to take care of pay patients, and because surgeons, not themselves engaged wholly in a charitable work, were permitted to use the operating rooms for certain fixed charges imposed upon their patrons able to pay, and because the dispensary or small drug store in the building sold drugs to its pay patients for a profit; the use of the property by the Sisters of Charity became thereby non-exclusive by them and so deprived the organization of its character as a purely public charity. The constitution does not in terms require a charitable institution, if it may claim exemption from taxation, to use its buildings exclusively for charitable purposes, as it does require in the case of educational institutions that they be used exclusively for educational purposes, but the requirement is only that the buildings be used for the charitable institution, . . .

Under a federal internal revenue statute 4, Fed. Stat. Am (2d Ed.) pp. 245-252 exempting from tax the income of corporations "organized and operated exclusively for religious, charitable, scientific or educational purposes, no part of the net income of which inures to the benefit of any private stockholder or individual, the United States Supreme Court recently held (44 Sup. Ct. 204) that a corporation sale, "does not lose its exemption by

reason of incidental earnings and profits, arising from its general charitable operations, where none of its members share in the profits." The court follows previous decisions of previous courts that the reception of pay cases as well as their predominance, does not destroy or impair the use of the property by the Sisters, nor does it change the character of the institution from one of purely public charity. The fact that such exemptions permit corporations of the type to accumulate large estates, impair competitive business enterprises, is within the power of the legislature to control.

#### Requirements for Tax Exemption

The hospital is declared to be a purely public charity within the legislative provision which requires:

"(1) The dispensation of its charities both to its members and others in sickness, distress, and death must be without regard to poverty or riches of the recipient; and

"(2) Its property and assets must be placed and bound by its laws to relieve, aid, and administer in any way to the relief of its members when in want, sickness, and distress, and provide homes for its helpless and dependent members."

Although the court holds that the institution is within the constitutional and statutory meaning of a purely public charity, it also points out that the net results of the hospital's operations were profitable.

"However charitable and benevolent the corporations may be, they are exempt from taxation only when their profits are solely appropriated (1) to sustain the institution; (2) for the benefit of the sick and disabled members and their families and the burial of same; and (3) for the maintenance of persons unable to provide for themselves . . ." which, according to the court, is borne out by testimony.

There seems to be no justification for the conclusion that "a charitable institution must necessarily be founded exclusively upon gratuities or donations, or that it closes its exemption status because it goes in debt for its plant and pays that debt, and the interest accruing on it, out of its incidental earnings, and certainly there is no language in our constitution or statute warranting such a determination.

"The theory upon which institutions of this character are exempted from taxation is that they serve the government by relieving it to some extent of what would otherwise be a public duty or governmental function to care for the indigent sick and afflicted, it is the assumption by such institutions of this burden which compensates the government for the exemption granted them from the general obligation resting upon all citizens to pay taxes. It is therefore essentially to the public interest that the facilities of these institutions to carry on this burden, be extended by additions, new structures, and building funds, looking to that end and keeping pace with a growing population and its increasing demand for charitable dispensations. . . . There is nothing in the record from which it may be inferred that any of the profits are being utilized for any purposes other than those well within the scope and purpose of the charities and benefactions of the hospital enterprise itself, as distinguished from a situation where profits arising out of the conduct of one charity are devoted to a different, segregated, or unrelated charitable purpose."

*Santa Rosa Infirmary v. City of San Antonio* 259 S W 926.

"Never to know that you are beaten is the way to victory."—Florence Nightingale.



# HOW ROCHESTER GENERAL HOSPITAL TAKES CARE OF ITS VISITORS

BY ELIZABETH LOWRY, DIRECTOR OF SOCIAL SERVICE, ROCHESTER GENERAL HOSPITAL, ROCHESTER, N. Y.

THE visitor entering the General Hospital, Rochester, N. Y., sees directly in front of him an attendant in a booth to which he naturally goes for information.

This booth is the headquarters of the service bureau. It is a well built eight-sided affair, the lower half of wood and the upper part of glass. One side is built against an angle of the wall while the other sides command a view of the main entrance, the ambulance entrance and the corridors which lead to the wings of the hospital. The windows open and close so that the worker is protected from the ever-opening outer doors. A door facing each corridor makes it easy to summon the visitor who fails to stop. The booth is equipped with a drawer and shelves for supplies and a telephone.

There are two workers on alternate weekly shifts from 8:30 a. m. to 2:30 p. m. and 2:30 p. m. to 8:30 p. m. The Sunday hours are 10 a. m. to 8 p. m.

The duties are numerous as the workers are asked about every phase of the hospital life. They are consulted about the proper feeding of the baby and invited to the christening. They direct the inquirer for "doctor clinic" to the dispensary. They sympathize when the patient is not better and rejoice when he improves.

The main duty of the workers, however, is to regulate the visits to patients. Rochester is a socially inclined city and not only a patient's family but his relatives to the most distant cousin-in-law and all his friends flock to the hospital to see him. Before the present system was inaugurated, fourteen visitors in a room ten feet square was not unknown. The climax came when a ward patient boasted of nineteen visitors in one afternoon. As only two chairs are provided for the visitors of each patient, some perched on the bed and some encroached on other patients' space, causing undue commotion.

Since our rules have been enforced the number of visitors has not diminished materially, but now they fill the main floor waiting room and overflow into the corridors, waiting their turn to go up when other visitors come down.

Two visitors at a time, from 10:00 a. m. to 8:00 p. m., are allowed the patients in the large single rooms. One visitor at a time, between 10:00 a. m. and 2:00 p. m. and two visitors at a time, between 2:00 p. m. and 8:00 p. m. may see the patients in small single rooms. One visitor at a time between 10:00 a. m. and 8:00 p. m. is allowed the patients in the private (2 or 3 bed) wards.

In the adult public wards the visiting hours are from 2:00 p. m. to 3:30 p. m. daily including Sunday and 7:00 to 8:00 p. m. daily except Sunday. Only one adult visitor at a time is allowed except on Saturday and Sunday afternoons when children are admitted. Only parents are al-

lowed to visit the children's wards and they are admitted from 2:45 to 3:30 daily and Tuesday and Friday evenings from 7:00 to 7:30 p. m.

The maternity patient in the private room may see her husband, his mother and her own mother for the first five days and after the fifth day two visitors at a time between 10:00 a. m. and 3:00 p. m. The maternity patient in the public ward may have only her mother, her husband and his mother and the hours are the same as those for the adult public wards.

Exceptions to these rules are made when circumstances demand, as in case of serious condition of the patient, visitors from out of the city, etc.

## Cards Help Keep Tab on Visitors

Every visitor entering the hospital is given a card at the service bureau. Different colors distinguish the cards, blue for private rooms, red for the wards and white for special permission. On the cards are the ward or room number, name of the patient, date of admission and a request that the card be returned to the service bureau at the conclusion of the visit. A card so returned may be reissued to another visitor.

Each card is kept in a small folder in an indexed box so that the worker at all times knows whether or not a patient has a visitor. Each morning the files are put in order. New cards are inserted for new patients, cards removed for those gone home, soiled cards replaced, etc. In the same folder with the cards are occasionally placed notes for the patient's family, perhaps making an appointment with the social worker, or asking for an interview with the cashier.

Assisting the paid workers are volunteer aides. One is on duty every morning and two in the afternoon. During the visiting hours the aides see that no visitor without a card enters the elevator, and clear the floors at the close of the visiting hour. At other times she delivers flowers, parcels and mail and acts as messenger for the service bureau. The volunteer aides, forty in number, are enrolled, instructed and assigned not only to the service bureau but to several departments of the dispensary by the very capable volunteer worker (a member of the board), who has the aid service in charge.

Both paid workers and volunteer aides wear attractive blue uniforms with white collars and cuffs and a blue and white cap.

The personnel of the service bureau is selected with care, as the attitude of the general public toward the hospital is influenced by the courtesy, tact and good judgment of the workers and their ability to make quick, just decisions.



A busy day at the service bureau of Rochester General Hospital.

## HARPER HOSPITAL DENTAL CLINIC

By ALICE H. WALKER, CLINICAL EXECUTIVE, HARPER HOSPITAL DENTAL CLINIC, DETROIT, MICH.

**F**OUR years ago Detroit, Mich., a city of one million inhabitants was without a dental clinic for the treatment of adult patients who could not afford to pay the price of good dentistry at prevailing charges of private dentists. The department of health provided such clinics for school children but gave emergency treatment only, to adults.

Recognizing the need of such a clinic from the standpoint of public health of the city, Harper Hospital opened a dental clinic for the treatment of adult patients. Three rooms in the basement of the dispensary were appropriated for this clinic, an operating room, a laboratory and a waiting room, which were adequately equipped for this purpose. A well-trained, full-time dentist was placed in charge and a young woman trained in prophylactic work was engaged, as assistant. The facilities of those indispensable adjuncts, the laboratory and x-ray departments were also available and have been utilized to the fullest extent.

From the day that the clinic first opened, April 21, 1919, until the present time it has been thronged with applicants. Many thousand people receive treatment annually with gratifying results. In many instances chronic patients of long standing have shown marked results after the foci of infection had been removed.

The clinic has been partially self-supporting from the first, the deficit being covered by the Detroit Community Fund. The service has not been limited to the patients of the hospital but has been available for the clients of all philanthropic organizations of the city. The patients are classified in four groups, ranging from those who can pay nothing to those who can pay the entire fee, which is much smaller than that charged by a private dentist. One afternoon a week is devoted to extraction of teeth under nitrous oxide gas, with an expert anesthetist, a doctor and nurse in attendance in addition to the dentist and his assistant. This service is available for the non-pay patient as well as for those who can make some financial return.

### Enlarge Quarters and Staff

The clinic has long outgrown its present quarters. It is now moving out of the basement into larger quarters on the third floor of the dispensary. Three dental chairs will then be provided. The staff will be augmented by two graduate dentists who will serve one year's internship. These young men will reside in the quarters provided for the medical residents and will receive \$100 a month remuneration.

In addition to the supervision of the dentist in charge of the clinic, instruction will be given by six dental experts of the city each of whom will devote one hour

weekly to work in the clinic. Lectures will be given by them and they will serve as consultants at all times. Special instruction will be given in the making of artificial dentures, root canal filling, prophylaxis, oral surgery, x-ray work.

### Schedule of Charges

The following is the schedule of charges for the ordinary types of work:

- Class 4 Plates \$10.00 each.  
Extractions free.  
Fillings, except gold, free.
- Class 3 Plates \$12.50 each.  
Extractions \$.10 each.  
Fillings, except gold, \$.25 each.
- Class 2 Plates \$15.00 each.  
Extractions \$.25 each.  
Fillings, except gold, \$.50 each.
- Class 1 Plates \$17.50 each.  
Extractions \$.50 each.  
Fillings, except gold, \$.75-\$1.00.

### Helped by City Funds

The cost of artificial dentures for non-pay patients is met by city funds or by funds of the different charitable organizations.

The patients are received by appointment only. Payment is required when the appointment is made. For the non-pay patient the money is refunded if the appointment is kept.

This system cuts down the number of broken appointments. For four hundred twenty-five patients there were only twenty-five broken appointments last month.

It is planned to enlarge the scope of the clinic to include industrial pay clinic in the near future.



A patient undergoing treatment at the Harper Hospital dental clinic.

### NEW SANTO TOMAS HOSPITAL TO BE DEDICATED, SEPT. 19

The formal dedication of the New Santo Tomas Hospital, which has been erected by the Republic of Panama, R.P., will take place at 4 p. m. September 19, 1924, under the direction of the inauguration committee as follows: Colonel Juan Antonio Jimenez, chairman, Major Edgar A. Bocock, M.C., U.S.A., Senor Don Luis E. Alfaro, Senor Don Juan J. Mendez and Senor Don Charles L. Stackelberg, who will act as master of ceremonies of an elaborate program. The presentation of the completed hospital will be made by Major E. A. Bocock, M.C., U.S.A., the chairman of the building committee and the acceptance will be made by Colonel Juan Antonio Jimenez, national secretary of public works. The hospital will then be officially opened by Doctor Belisario Powas, president of the Republic of Panama.



## MOUNTAIN SANATORIUM "LISTENS IN"

BY T. H. WATSON, BACTERIOLOGIST, MOUNTAIN SANATORIUM, HAMILTON, ONT.

**R**ADIO has become an important aid in the rest cure treatment of tuberculosis at the Mountain Sanatorium, Hamilton, Canada.

In sanatoriums where rest is the first principle in treatment it has always been difficult to provide sufficient diversion of interest to overcome the tendency towards inertia in some patients, and encourage others who are restless to take the cure more diligently.

Three methods of overcoming this problem are employed at Hamilton. The first, and easiest to provide, is a good library. The second that has proved of much value is occupational therapy, where bedside aids, under medical supervision, instruct the patients in making novelties. The third method that has now developed to the stage where it has been successfully employed is radio entertainment. This helps greatly to dispel the feeling of isolation which tends to develop in institutional treatment. A judicious combination of these three methods has brought about a vast improvement in rest cure treatment over the monotonous routine of a decade ago.

The sanatorium's radio installation, at the time of writing, has been in use four months. The money for the complete installation was generously given by Mr. C. S. Wilcox a director of the sanatorium.

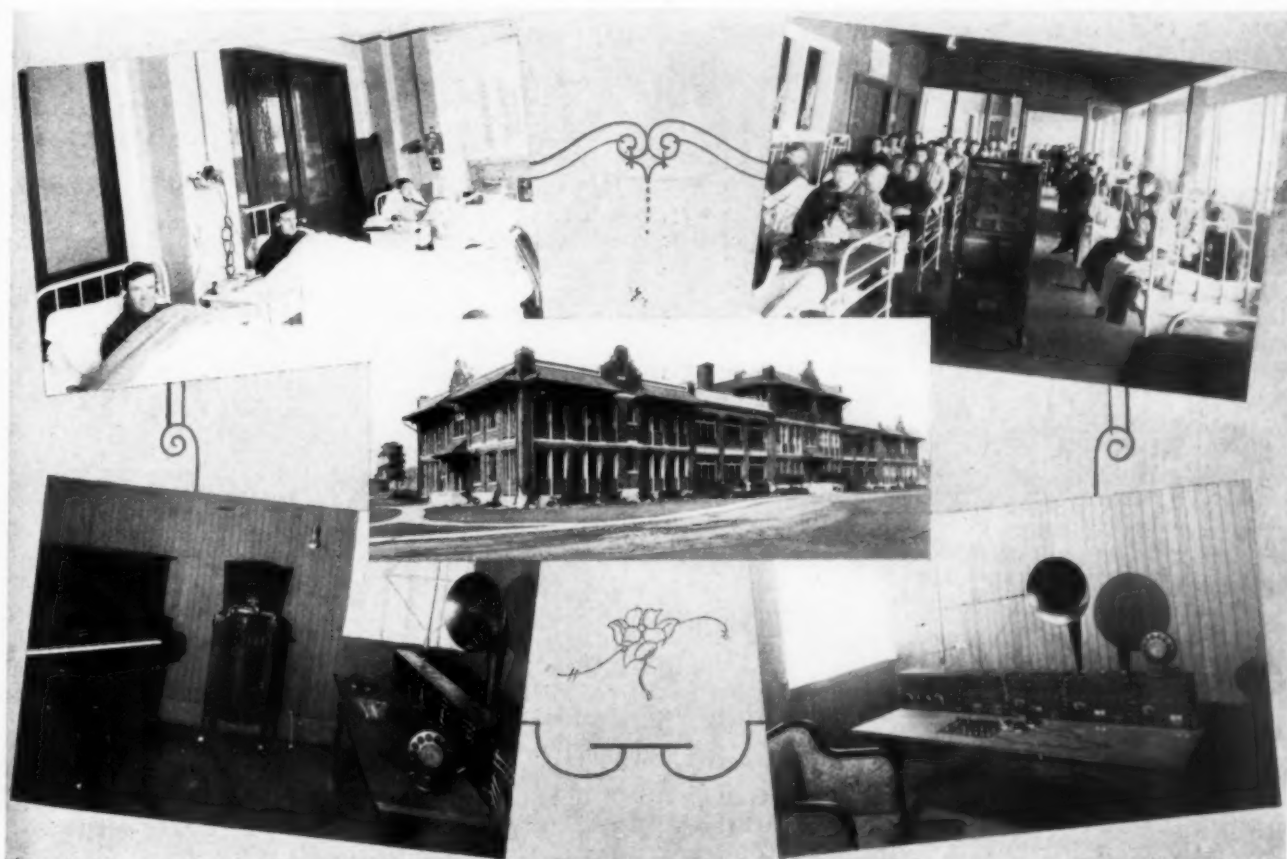
The receiving set consists of a tuning unit containing two stages of transformer coupled radio frequency amplification, a detector, and one stage audio frequency ampli-

fication, using peanut tubes. Then follows two power amplifying units each containing three stages of audio frequency, the last stage of each unit being push pull. One of these amplifying units actuates the head sets at 125 outlets in buildings situated one-half mile distant from the radio room. The other amplifying unit actuates 150 head sets in buildings within a radius of 200 feet of the radio room.

The speech amplifier may be seen at the right of the photograph of the receiving set. It is connected to the microphone and to the two power amplifiers mentioned above. The microphone is a very useful feature of the equipment and is used either in the concert hall or the radio room. By its use bed patients may listen to the lectures given by the medical staff, as well as to the local concerts and church services.

The batteries consist of five storage "A" batteries and five Edison type "B" batteries. These together with the necessary charging equipment, are in a separate room.

To connect the 275 outlets to the central receiving set it was necessary to use 6,000 running feet of double, twisted outside wiring and 2,500 feet of double, twisted inside wiring. In the main building the wiring for eighty outlets is run through square metal conduit. A loud speaker may be used at any outlet in the system by connecting at that point one or two stages of audio



Infirmery and administration building, Mountain Sanatorium, Hamilton, Ont.

(Upper left) the radio room at Mountain Sanatorium, Hamilton; (upper right) patients listening in; (lower left) children of the preventorium listening to the "Dream Lady" who is telling a story in the radio room one-half mile away; (lower right) central radio receiver and microphone, the largest and most complete equipment of its kind known to date.

frequency amplification. A loud speaker is used instead of head sets for the seventy-five children of the preventorium. As it is difficult to get children's programs at suitable hours, one of the members of the staff puts on bedtime stories by means of the radio room microphone. This enables the "Dream Lady" to add many little personal touches much to the delight of the children.

Loud speakers are not used in the wards of the adult patients, but within easy reach of each bed is an outlet for head phones. This system makes it optional whether the patients listen in to all the radio programs which are sent over the lines. Loud speakers in use tend to make the wards and patients noisy.

The set is in use one and one-half hours each afternoon and three hours each evening. Once a week, when special features such as drama from Schenectady or opera from Chicago are "on the air," permission is given to continue later than 9:30 p. m. in order to conclude the program.

The central radio receiving set idea has worked out well at Hamilton. It is considered by Dr. J. H. Holbrook, the medical superintendent, to be of very definite value in the rest cure treatment of tuberculosis. The patients are of one accord in their praise of it; and the bursar is happy to find that it has cost only twenty dollars to maintain the plant for the first four months it has been in use.

### COMMITMENT PROCEDURE AND THE STATE HOSPITAL

In a recent issue of *Mental Hygiene* the subject of "Commitment Procedure and the State Hospital" is analyzed in its many aspects and treated in a thorough and interesting discussion. The author makes clear that commitment procedure is closely associated with the evolution of the conception of insanity and the old and new ideas as to the function of the state hospital. The great breadth of the term "insane" and its varied degrees of meaning from the lay and professional viewpoints and its effect upon confinement in state hospitals is interestingly developed.

The evolution of the term "insane" from the earliest times when peculiar behavior was considered as the result of a visitation from heaven or hell to the present day when we consider insanity as an unbalanced state of mental and physical properties in the individual mechanism has had a decided influence upon those who were and are considered proper subjects for treatment in the state hospital.

Before hospitals were established for the treatment of the insane the anti-social insane were first treated as criminals and were imprisoned, executed or punished in other ways which, at the time, were considered fitting, but which, from the modern viewpoint, seem cruel and intolerable.

In the next stage of development of our attitude toward the insane, we became more humane and began to try to help the insane by establishing asylums or hospitals in which the patients were treated by moral means through persuasion and teaching, and were placed in rather attractive isolation which because of its conduciveness to meditation was thought influential in their cure.

Parallel with the development of cellular pathology in medicine and the growth of materialism came the belief that the disordered function was due to organic defect. Accordingly, the hospitals in which the insane were segregated were placed under medical management.

Admission to the hospital for the insane was then by voluntary application or by that of relatives or friends.

The legal concept of insanity has grown out of dealings with the anti-special insane and has unfortunately become the only precise definition of the word.

The government of the state hospital at that time was an autocratic rule of despotism placed in the hands of the superintendent who exerted a far-reaching influence in all matters of abnormal behavior. Statistics of the most optimistic nature were regularly sent out by the hospital setting forth the large percentage of cures which were annually turned out of the hospital. Of course these large percentages were based upon the discharges only, and many of the same patients were discharged several times a year.

As a reaction to this period of optimism concerning the cure of the insane followed a period of legislation to protect the insane. This made it more difficult for a person to become a patient in a state hospital and made commitment more of a legal and less of a medical matter. The insane were "charged" with insanity and were dealt with in the same manner as criminals with all of the attendant official procedures. All of this matter was thought necessary in order that society should be protected from an individual dangerous to life and property and that the accused might be protected. Once commitment was executed the lay attitude toward insanity thus became one of fear, suspicion and hopelessness.

The term insanity has come to have three interpretations; the lay, the legal, and the medical. To the layman of today the term insanity implies unusual, unconventional and often anti-social behavior. In a legal sense, it connotes behavior of such a character as to warrant the segregation from society of the individual manifesting it, and due trial by court in a setting that frequently savors of criminality. The medical or psycho-biological meaning of the term is based on the study of frank cases, usually the end stages of a process that has been advancing for a long time. It denotes abnormal behavior in that it is out of accord with reality. These three definitions thus permit of a wide range of discrepancy.

Up until quite recently the state hospital for the insane has been closed to all but the legally insane. Admission to the state hospitals based upon the psychiatric viewpoint did not come until people began to realize that mild cases outside the legal category of the term should be given attention through the state hospital. This was brought about by a movement for the state hospital for the insane to become an active reconstructive and reeducative institution.

The first step in furthering the movement was the enactment of the voluntary-commitment law which permitted suitable cases to enter the hospital without court procedure and without the sacrifice of civil status. And this is the only step that has been taken in harmony with the modern trend of psychiatric opinion. This voluntary commitment has done much to destroy the unhealthy, undesirable suspicion dependent upon the former commitment to the insane hospital.

Considered from a medical viewpoint, facilities for the care of the insane are very inadequate in many communities. The conception of insane will have to be divorced from its legal aspect before admission to the hospital will become easy and devoid of humiliation.

Up to the present, only a few communities have altered their statutes to make possible the initiation into practice of this new concept. If the state hospital for the insane is to become a center of mental hygiene the present commitment laws will have to be amended so that the legal aspect will be minimized and admission to the hospital made easier.

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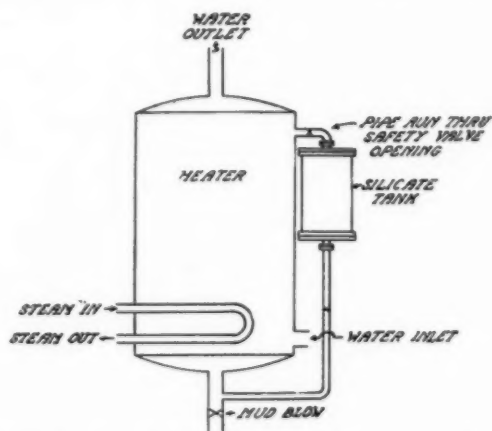


## THE INFORMATION DESK

*No satisfactory solution to a problem in your hospital is too trivial to pass on to other workers in the field. No question that perplexes you is too small to bring to the attention of those with greater experience in the field. This department is the readers' exchange, and its usefulness is dependent upon the measure in which its readers share their problems and their discoveries.*

### RUST PREVENTION IN HOT WATER AND STEAM PIPES

According to a report made by Robert P. Russell, research laboratory of applied chemistry, Massachusetts Institute of Technology, sodium silicate, or water glass, may be used to prevent rust from forming in hot water and steam pipes. Mr. Russell's tests which have extended over a period of two years, were made in connection



Apparatus for admitting sodium silicate to water heater.

with an apparatus devised by F. N. Speller, National Tube Company. As rust gradually destroys hot water and steam pipes in all departments, its prevention is everywhere desirable for that reason; but in the laundry department there is another reason that is still stronger. When rust is injected into the washing machine with the steam or hot water, the goods will be discolored with a material that only oxalic or some similar acid will remove.

The method of applying this apparatus to a water heater is shown in the accompanying diagram. Solid sodium silicate is placed in the small container shown at the right of the heater. Natural circulation causes a small quantity of the hot water to pass upward through the small pipe, through the silicate chamber, and into the heater, thus bringing a small quantity of the silicate with it. At night, when no water is drawn, the water in the heater picks up a very little silicate, about twenty

parts to the million. This solution is drawn off in the morning, and after the pipes have been cleared the hot water is substantially free from the silicate. The presence of a small amount of the silicate will do no harm, however, it is stated, and as it has a tendency to soften the water it may effect some slight economy in soap.

The silicate, it is explained, forms a coating on the inside of the pipes, and as it excludes the air prevents the formation of oxide of iron, or rust. In the installation shown, the "red-water" evil ceased to exist, and there was no further trouble with iron stains in the goods washed. When the silicate was cut out of the system for experimental purposes, the iron rust returned in about two weeks. The cost of the material is negligible, and it only has to be renewed once in four months. A simple water analysis should be made each month, but this involves only twelve to fifteen hours a year.

In his summary the chemist says: "(1) Treatment with sodium silicate, or water glass, almost entirely stops red water and greatly lowers the corrosion of iron and steel heaters and pipe lines. (2) This treatment is possible in waters varying in hardness from the relatively hard Pittsburgh water (85 r. p. m.) to a softened water (practically 0 r. p. m.). (3) The treatment harms neither water nor clothes, and if anything it decreases the amount of soap required in washing.

An efficient water-treating system will, of course, remove any iron that may be present in the water, as well as all other forms of hardness. The zeolite softeners give water of "zero" hardness, or no hardness at all. Paradoxically, the softening of the water, where hard water has been previously used, may result in the appearance of red-water and its consequent troubles. When hard water is used, the pipes will be covered inside with an incrustation of lime or magnesium, and this will prevent oxidation, or rust. As soon as the use of soft water begins, the incrustation begins to disappear, and finally the pipe is clean enough to permit the oxygen to form rust. In such a case as this, it would seem, treatment with water glass will remove the trouble.

### SAVING CLEANING POWDERS

Excessive use of cleaning materials of any kind has just the opposite effect to what is desired. It is extravagant to use more than the amount necessary to soften the water. This can be ascertained by wetting the finger tips and rubbing them against one another. When the water is properly softened the soap content of the powder becomes effective. The softening element in the powder is a chemical which, if used too freely, causes the water to react and take on a hardness greater than it had before any powder was added to it.—*The Bulletin of the California Lutheran Hospital.*

## NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,

2040 Stearns Road,  
Cleveland, Ohio.

### THREE CLEVELAND SCHOOLS OF NURSING MERGE IN LARGER SCHOOL\*

IT IS perhaps inevitable that the term "University School of Nursing" should bring to the mind of each one of us the university school which we happen to know most about, and so I have tried to bring together within the compass of this brief paper the interesting details in connection with the school of nursing at Western Reserve University.

I am somewhat afraid that my attitude toward the new school in Cleveland is comparable to the attitude of a mother toward her first-born child. Naturally the mother thinks her child is most unusual and finds it difficult to restrain her enthusiasm and joy over every evidence of its life and growth. Probably she spends much time daydreaming about the progress the child will make, and builds wonderful air castles with her child as the hero, the central pivotal creation around which much that is good will cluster, and from which great good will radiate. I say this by way of explanation, because the school at Western Reserve University is only a year old, really in its very beginnings, and it is difficult to remember that the sum total of our accomplishments is small compared to the plans and prospects for future development.

I have always prided myself on being a truthful person, but I found the task of building the catalogue very illuminating, for it was necessary to stick to absolute facts and disentangle our infant school from the dreams that have become almost an integral part of it.

For years previous to 1921 various groups including lay and professional people have worked and planned for a university school in Cleveland. Too much credit can not be given to these groups, for it is always easier to work with a concrete thing that has been started and is a nucleus for future plans, than to create from dreams and ideals something that is tangible and real. To those early dreamers who worked unceasingly to make their dreams come true, and in the process of making them come true have made all sorts of sacrifices and adjustments, I gladly pay tribute.

To realize the dreams of its founders the school of nursing at Western Reserve University must reach the very highest level. This in itself is a stimulating challenge, and has made the adoption of high standards a foregone conclusion. Anything less would be an anticlimax of a very sad sort.

In September, 1921, a department of nursing education was established in the college for women, and a curriculum

for five-year students was adopted. This curriculum was neither ideal nor complete but it represented a beginning and a workable combination of the best the college and the hospitals had to offer. For the first year nine students enrolled for the five-year course. The second year ten new students enrolled. During the first two years the work of the department emphasized the teaching of the five-year course, but was not confined to this. Courses in home nursing were given to the students in the college for women; courses in the principles of administration and teaching were given to graduate nurses. These courses were planned to meet the needs of the nurses serving as supervisors and heads of departments in the various schools of Cleveland, and an effort was made to familiarize them with the problems confronting the department and the attempts which were being made to solve them.

Much time was spent with various groups and committees and every possible effort was made to enlist the interest of as wide a circle as possible. Cleveland is noted for its success in carrying out community projects, and one valuable by-product of the community chest fund is that even the oft-quoted "man in the street" knows something of hospital service—something of what it means and what it costs.

#### Gift of \$500,000 for Nursing School

In April, 1923, Mrs. Chester C. Bolton's gift of \$500,000 was announced, and in June the trustees of the university authorized the merging of the department of nursing education in a school of nursing, on an interdependent basis with the college for women and the other colleges and schools in the university. Many of us are still reacting to the thrill that followed the announcement of Mrs. Bolton's gift, and I know that all nurses everywhere are as anxious as those directly connected with the school that this gift shall yield as large returns to nursing education as the two former gifts have done. When one thinks of Florence Nightingale's endowment of St. Thomas's school of nursing in London, of Mrs. Helen Hartley Jenkins' gift to the department of nursing education at Teachers College, Columbia University, New York, and of the far-reaching results of these gifts, one cannot but hope that Mrs. Bolton's gift, the largest of the three, shall prove of equal service.

That Mrs. Bolton was no stranger to nurses, that she had worked with nurses for years—someone has said she knew the worst and the best of us—that she knew

\*Paper read by Miss Carolyn E. Gray at the biennial national nursing convention, Detroit, Mich., June, 1924.



our aims and ideals, our successes and failures, as well as the complexities of the problems of nursing education, and yet had faith that these problems could be worked out in accordance with university standards, is nothing short of a challenge to prove her faith justified.

### Three Schools Merge in Larger School

Fortunately the recommendations of the Cleveland Hospital and Health Survey, and the report of the committee on nursing education were available, and our plans are based on these. Because it was unthinkable to attempt work with all the schools of nursing in Cleveland at one time, even had they all wanted to come in, it was decided to develop the school in connection with the hospitals that serve as teaching hospitals of the university and that seem destined to become integral parts of the university. These are Cleveland Maternity Hospital, Babies' Dispensary and Hospital and Lakeside Hospital, the three which are included in the so-called "group plan" and are to occupy space adjacent to the new medical school. Two of these schools of nursing, Maternity and Babies', are in process of erection. Lakeside's school of nursing is to be started in the near future. In two of these hospitals schools of nursing were in operation; in the Babies' Dispensary and Hospital the teaching of student and graduate nurses has been carried on for years, but not as a separate school.

Part of our problem was how to use the teaching facilities of these three hospitals to the best advantage and preserve all the good things the existing schools had developed.

I shall always count it a rare privilege to have witnessed the gradual development in the minds of those responsible for the schools, of the idea of sinking their identity and merging in the larger school. Gradually it came to them that one school which was in very truth the university school, would be better than three schools connected with the university school. The Maternity Hospital school of nursing led the way and was the first to merge, thus becoming the obstetrical department of the university school. This school had been in existence only four years, which meant that it had just passed through the difficult period of organization and early development. It meant a complete reversal of a policy which had become familiar and was working smoothly. We have only to look into our own minds and hearts to appreciate what this action meant.

### Lakeside Takes Broad View

Then Lakeside school of nursing, with twenty-six years of growth and service behind it, with an army of 679 graduates, with a board of managers and a board of trustees who justly regarded the school as something they had brought into being and had helped to bring to a high stage of development, decided to merge and become the surgical and medical department of the university school.

The particular kind of loyalty which is an outgrowth of such contributions as all these groups made to the school, naturally made it difficult at first, for them even to think of the school losing its identity in the larger school. But the various groups connected with Lakeside Hospital had been leaders in bringing the university school of nursing into existence, and it was inevitable that they should accept and act upon the idea of merging, even though it meant self-sacrifice of a kind that we all shrink from. That this sacrifice was made gladly and in a happy way stands to the everlasting credit of Lakeside Hospital, and is a just source of pride to all those who hold the traditions of its school of nursing near and dear. In periods

of doubt and discouragement this cannot but serve as a tonic to one's faith in the essential courage and generosity of human nature.

Those of you who are familiar with Galsworthy's "Loyalties" will recall how the different characters were loyal to the one individual, group, or tradition they held most dear, but failed utterly to sense the need for loyalty to the bigger and all-embracing thing which in this case was the truth. How many of us are comparable to the characters in this play? We are loyal to our own school, loyal to its traditions, ready to talk of its accomplishments and eager to gloss over its failures. How many of us would be willing to have our school sink its identity even in a larger thing which it had helped to bring about? How many of us, if brought face to face with this problem would stand up to it and "go smiling through" to its solution?

I dwell on this because it is heartening to appreciate the full significance of the loyalty of all whom we might call Lakesiders to their own school, expressed in terms of their loyalty to the bigger and all-embracing thing which in this case is the best possible type of nursing education. Moreover, I wonder if Lakeside is not a standard bearer and has not blazed the pathway that many other schools will find easier to travel because of its brilliant example. It is conceivable that the merging of a number of schools, resulting in fewer and stronger schools, may prove a healthier condition than the steady increase we are all familiar with.

Equally generous has been the decision of the Babies' Hospital and Dispensary not to start a school of its own but to merge with the university school as the others had done, thus becoming the pediatric department of the university school.

### City Hospital Cooperates

The combined resources of these hospitals furnish medical, surgical, obstetrical and pediatric experience, but do not include experience in the care of communicable diseases and mental and nervous cases. An appeal to the City Hospital of Cleveland to allow us to send our students to their new departments for experience in these essential services met with a ready response, and an affiliation has been arranged.

Miss Calvina MacDonald and Miss Laura M. Grant, formerly principals of the schools of nursing at the Maternity Hospital and Lakeside Hospital, have been appointed on the faculty of the university school. Appointments from the Babies' Hospital and Dispensary and the City Hospital are pending. These appointments tend to unify and correlate the work of the different hospitals, as questions of policy are always submitted to the members of the faculty sitting as a board, and then if need be referred to the advisory committee of the school.

### University School a Community Project

The organization of this advisory committee may be of interest. The president of the university and three trustees were appointed as a special committee for the school of nursing, with the privilege of adding to its membership those people who, in its judgment, would best further the development of the school. The privilege was acted upon and twelve members were added to the committee. The university hospitals are each represented by two board members, with two alternates. The City Hospital is represented by the welfare director; other hospitals in Cleveland by the first vice chairman of the Cleveland Community Fund; the medical profession by

two doctors; the visiting nurse association, the University public health nursing district and the central committee on nursing each have a representative. This means that the twelve members which the trustees invited to serve represent all the varied nursing activities carried on in Cleveland, and serve as delegates to bring back to the respective boards they represent the deliberations and conclusions of this advisory committee.

This represents the community relationship of the school, and its connection with all the hospitals and groups who are interested in problems of nursing education. It is evidence of the intention to develop the university school as a community project, and, as soon as practicable, to extend the use of its teaching facilities to all the schools in Cleveland that are willing to comply with the standards set by the university.

The school of nursing is indebted to the college for women for the opportunity of developing within its buildings until such time as the school of nursing building is erected, and for all the advantages and opportunities of college life which the school of nursing students share with the college for women students.

The facilities for instruction include the undergraduate schools of the university—Lakeside, Maternity, Babies' and City Hospitals—and the University Public Health Nursing District. The students of the schools of nursing are admitted to the undergraduate colleges on the same basis as those from other schools in the university.

#### College and School Interdependent

The offices of the school of nursing are in Mather Hall, Rooms 10, 11, of the college for women. The relationship between the college for women and the school of nursing is on an interdependent basis, the college for women giving instruction to students from the school of nursing, and the school of nursing giving instructions to students from the college for women.

It is planned that this cooperation will be continued and developed. The nursing students gain much from association with the college students in history, language and other classes. On the other hand, the college students get their instruction in home nursing and in elementary physiology and hygiene in the school of nursing. Elementary physiology and hygiene is not a required course, but enrollment is encouraged and about seventy per cent of the freshman class register for it. The fact that the department of physiology is in the school of nursing gives us a much coveted opportunity to meet the freshmen students and have them know something of the school of nursing.

The clinical experience in general medicine, surgery, and the care of children is given at Lakeside Hospital. The capacity of the present hospital is 298 beds and offers an active and varied service. An active dispensary, including all types of clinics, is an invaluable department of this hospital and we are studying how to make the best use of this for teaching purposes.

The clinical experience in the care of obstetrical cases, including prenatal and postpartum care, is given at the maternity hospital, which has a capacity of 120 beds, sixty for mothers, and sixty for babies. Much of the field work is carried on in connection with the eight prenatal dispensaries. The new maternity hospital will have a capacity of 300 beds, 150 for mothers and 150 for babies.

The new Babies' Hospital will accommodate 150 children. The students will get their experience in the care of children at this hospital.

For experience in the care of communicable diseases and mental and nervous cases, an affiliation has been worked out with the Cleveland City Hospital. These departments are occupying new buildings recently completed and modern in every detail. The capacity of these two departments is 589 beds, 445 for communicable diseases and 144 for mental and nervous cases.

Experience in public health nursing is secured in connection with the University Public Health Nursing District. The district, which is used as a practice field, is a crowded one and affords a varied experience in generalized public health nursing. This arrangement eliminates the waste of time inevitably resulting from assignments of work distributed among several agencies, and, what is still more important, it teaches the student methods of dealing with every type of health problem encountered in the families she visits, and thus forms an excellent preparation for community work.

#### Range of Subjects Covered

The program of study is planned for three groups of students: (a) The five-year group, (b) the three-year group, (c) the graduate-nurse group.

The five-year program is planned to meet the requirements for a bachelor of science degree and a diploma in nursing.

The aim is to give the student in her first two years (or pre-hospital period) an introduction to the general cultural subjects which are considered fundamental in any college training, to give her a good foundation in the sciences and to have her share in all the social and cultural opportunities of college life. One month each summer is spent at Lakeside, and this, added to excursions to other hospitals, enables the student to get a fairly concrete idea of the field she is about to enter.

The third and fourth years are devoted to fundamental professional training in the university hospitals (so-called basic training).

The fifth year is largely elective, the student electing one of several branches of nursing in which she is deeply interested, and devoting herself to the theoretical and practical work required for that branch. Approximately one-half of the student's fifth year is spent in field work, and the other half in theoretical work. At the end of this time she graduates with her diploma of nursing and her bachelor of science degree.

The three-year program is planned to meet the requirements for a diploma in nursing. The aim is to give the student in the four months' preparatory (or pre-hospital) period, such intensive instruction as will enable her to meet the responsibilities she assumes when she begins her clinical experience.

For the present this preparatory work will be given at Lakeside Hospital, but plans for a teaching building for the school of nursing are being worked out. As soon as this building is available the four months' pre-hospital work will be given in the teaching building on the university campus.

The following two years (twenty-four months) are devoted to fundamental professional training in the university hospitals, and are comparable to the two years' basic training of the five-year course.

The last eight months the student is given an opportunity to elect advanced experience in the nursing of medical, surgical and obstetrical cases, in the care of children, communicable diseases and psychiatric cases, operating room experience, dispensary, and some forms of public health work.



Two programs are offered graduate nurses, one in teaching and supervision in schools of nursing, and one in administration and supervision in schools of nursing. Each represents two years' work or sixty semester hours. The work of thirty-three semester hours is in required subjects, leaving twenty-seven semester hours for electives.

The present enrollment is: 22 five-year students; 134 three-year students.

### Strong, Progressive School is Aim

In connection with these plans we have tried to evolve standards that are practical and possible. I say "practical and possible" advisedly, because there are standards we would, I assume, all agree ought to be adopted by our hospitals, and yet it is no easy task to put them into effect, and keep them in effect. We estimate that it will take at least two years to put them into effect, and then it will take eternal vigilance and willingness to make constant adjustments to keep them functioning.

Perhaps you may be interested to know that the standard which we have found most difficult is the one which calls for the correlation of classroom instruction and hospital training. It is so easy to say that classroom instruction shall precede, or be given simultaneously with, hospital training, but until you actually try to do it you have no idea how many pitfalls it involves. But even here I feel we are making progress, and have learned some things.

Perhaps just here is a good place to mention the intensive study that has been made of the health standards and sickness rate of our student nurses. This has occupied much of the time of a physician and nurse, whose interest in the problem has been very great.

It is hardly safe to talk of plans for the future for the possibilities are limitless. A teaching building for the school of nursing is a necessity because the capacity of Western Reserve University is taxed to the uttermost by the present enrollment and it is quite impossible to find space for the classes of three-year nursing students. The reorganization of the university and the possibility of removal to another site, two subjects that have been much discussed this past year, make it difficult to plan for a permanent building. However, the new hospital buildings are progressing rapidly and plans for a temporary building are under way. By "temporary" I mean one that will meet the teaching needs of the students of the university school and the other schools in Cleveland for a period of about five years.

It is with mingled feelings of relief and reluctance that I turn over this school to my successor, Miss Louise M. Powell, in whose capable hands I am happy to leave it, with every confidence that on the foundations we have laid, a structure of true beauty will be built. It has been a high privilege to have been identified with this piece of work during the past three years, which have been interesting and educational in the best sense of both words.

### THE SOCIAL VALUE OF GLEE CLUB WORK IN TRAINING SCHOOLS

By ELIZABETH M. DELAHUNT, R.N., Directress of Nurses, Pittsburgh Training School for Nurses, Homeopathic Hospital, Pittsburgh, Pa.

THE social life of the student nurses in our training schools has received all too scant attention. If we wish to develop school spirit we must devote time, energy and money to social activities. *Esprit de corps* does not happen accidentally; it must be fostered.

In order to develop the social side of students they must be given sufficient time to carry on social activities.

The emphasis in the past has been on practice in the wards. It would be well for all concerned if we could strike a happy medium or sort of middle ground policy with our student group. We know it is the social hours in our lives that we cherish, and let us hope we will make more of these precious associations and opportunities for our young women. The time and money will bring abundant returns.

In September, 1923, we organized a glee club in the Pittsburgh Training School for Nurses in connection with the Homeopathic Hospital, Pittsburgh, Pa. All members of the school were asked to join and were requested to sign their names if they wished to have a glee club. The only requirement or obligation about the organization was a promise of regular attendance. Those who were not members took turns in relieving those on the wards for the glee club practice night, which was held regularly every Monday evening from 7:15 to 8:45. Members of the graduate staff interested were welcomed, and their presence and cooperation greatly strengthened the organization.

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two doctors; the visiting nurse association, the University public health nursing district and the central committee on nursing each have a representative. This means that the twelve members which the trustees invited to serve represent all the varied nursing activities carried on in Cleveland, and serve as delegates to bring back to the respective boards they represent the deliberations and conclusions of this advisory committee.

This represents the community relationship of the school, and its connection with all the hospitals and groups who are interested in problems of nursing education. It is evidence of the intention to develop the university school as a community project, and, as soon as practicable, to extend the use of its teaching facilities to all the schools in Cleveland that are willing to comply with the standards set by the university.

The school of nursing is indebted to the college for women for the opportunity of developing within its buildings until such time as the school of nursing building is erected, and for all the advantages and opportunities of college life which the school of nursing students share with the college for women students.

The facilities for instruction include the undergraduate schools of the university—Lakeside, Maternity, Babies' and City Hospitals—and the University Public Health Nursing District. The students of the schools of nursing are admitted to the undergraduate colleges on the same basis as those from other schools in the university.

### College and School Interdependent

The offices of the school of nursing are in Mather Hall, Rooms 10, 11, of the college for women. The relationship between the college for women and the school of nursing is on an interdependent basis, the college for women giving instruction to students from the school of nursing, and the school of nursing giving instructions to students from the college for women.

It is planned that this cooperation will be continued and developed. The nursing students gain much from association with the college students in history, language and other classes. On the other hand, the college students get their instruction in home nursing and in elementary physiology and hygiene in the school of nursing. Elementary physiology and hygiene is not a required course, but enrollment is encouraged and about seventy per cent of the freshman class register for it. The fact that the department of physiology is in the school of nursing gives us a much coveted opportunity to meet the freshmen students and have them know something of the school of nursing.

The clinical experience in general medicine, surgery, and the care of children is given at Lakeside Hospital. The capacity of the present hospital is 298 beds and offers an active and varied service. An active dispensary, including all types of clinics, is an invaluable department of this hospital and we are studying how to make the best use of this for teaching purposes.

The clinical experience in the care of obstetrical cases, including prenatal and postpartum care, is given at the maternity hospital, which has a capacity of 120 beds, sixty for mothers, and sixty for babies. Much of the field work is carried on in connection with the eight prenatal dispensaries. The new maternity hospital will have a capacity of 300 beds, 150 for mothers and 150 for babies.

The new Babies' Hospital will accommodate 150 children. The students will get their experience in the care of children at this hospital.

For experience in the care of communicable diseases and mental and nervous cases, an affiliation has been worked out with the Cleveland City Hospital. These departments are occupying new buildings recently completed and modern in every detail. The capacity of these two departments is 589 beds, 445 for communicable diseases and 144 for mental and nervous cases.

Experience in public health nursing is secured in connection with the University Public Health Nursing District. The district, which is used as a practice field, is a crowded one and affords a varied experience in generalized public health nursing. This arrangement eliminates the waste of time inevitably resulting from assignments of work distributed among several agencies, and, what is still more important, it teaches the student methods of dealing with every type of health problem encountered in the families she visits, and thus forms an excellent preparation for community work.

### Range of Subjects Covered

The program of study is planned for three groups of students: (a) The five-year group, (b) the three-year group, (c) the graduate-nurse group.

The five-year program is planned to meet the requirements for a bachelor of science degree and a diploma in nursing.

The aim is to give the student in her first two years (or pre-hospital period) an introduction to the general cultural subjects which are considered fundamental in any college training, to give her a good foundation in the sciences and to have her share in all the social and cultural opportunities of college life. One month each summer is spent at Lakeside, and this, added to excursions to other hospitals, enables the student to get a fairly concrete idea of the field she is about to enter.

The third and fourth years are devoted to fundamental professional training in the university hospitals (so-called basic training).

The fifth year is largely elective, the student electing one of several branches of nursing in which she is deeply interested, and devoting herself to the theoretical and practical work required for that branch. Approximately one-half of the student's fifth year is spent in field work, and the other half in theoretical work. At the end of this time she graduates with her diploma of nursing and her bachelor of science degree.

The three-year program is planned to meet the requirements for a diploma in nursing. The aim is to give the student in the four months' preparatory (or pre-hospital) period, such intensive instruction as will enable her to meet the responsibilities she assumes when she begins her clinical experience.

For the present this preparatory work will be given at Lakeside Hospital, but plans for a teaching building for the school of nursing are being worked out. As soon as this building is available the four months' pre-hospital work will be given in the teaching building on the university campus.

The following two years (twenty-four months) are devoted to fundamental professional training in the university hospitals, and are comparable to the two years' basic training of the five-year course.

The last eight months the student is given an opportunity to elect advanced experience in the nursing of medical, surgical and obstetrical cases, in the care of children, communicable diseases and psychiatric cases, operating room experience, dispensary, and some forms of public health work.



Two programs are offered graduate nurses, one in teaching and supervision in schools of nursing, and one in administration and supervision in schools of nursing. Each represents two years' work or sixty semester hours. The work of thirty-three semester hours is in required subjects, leaving twenty-seven semester hours for electives.

The present enrollment is: 22 five-year students; 134 three-year students.

### Strong, Progressive School is Aim

In connection with these plans we have tried to evolve standards that are practical and possible. I say "practical and possible" advisedly, because there are standards we would, I assume, all agree ought to be adopted by our hospitals, and yet it is no easy task to put them into effect, and keep them in effect. We estimate that it will take at least two years to put them into effect, and then it will take eternal vigilance and willingness to make constant adjustments to keep them functioning.

Perhaps you may be interested to know that the standard which we have found most difficult is the one which calls for the correlation of classroom instruction and hospital training. It is so easy to say that classroom instruction shall precede, or be given simultaneously with, hospital training, but until you actually try to do it you have no idea how many pitfalls it involves. But even here I feel we are making progress, and have learned some things.

Perhaps just here is a good place to mention the intensive study that has been made of the health standards and sickness rate of our student nurses. This has occupied much of the time of a physician and nurse, whose interest in the problem has been very great.

It is hardly safe to talk of plans for the future for the possibilities are limitless. A teaching building for the school of nursing is a necessity because the capacity of Western Reserve University is taxed to the uttermost by the present enrollment and it is quite impossible to find space for the classes of three-year nursing students. The reorganization of the university and the possibility of removal to another site, two subjects that have been much discussed this past year, make it difficult to plan for a permanent building. However, the new hospital buildings are progressing rapidly and plans for a temporary building are under way. By "temporary" I mean one that will meet the teaching needs of the students of the university school and the other schools in Cleveland for a period of about five years.

It is with mingled feelings of relief and reluctance that I turn over this school to my successor, Miss Louise M. Powell, in whose capable hands I am happy to leave it, with every confidence that on the foundations we have laid, a structure of true beauty will be built. It has been a high privilege to have been identified with this piece of work during the past three years, which have been interesting and educational in the best sense of both words.

### THE SOCIAL VALUE OF GLEE CLUB WORK IN TRAINING SCHOOLS

By ELIZABETH M. DELAHUNT, R.N., Directress of Nurses, Pittsburgh Training School for Nurses, Homeopathic Hospital, Pittsburgh, Pa.

THE social life of the student nurses in our training schools has received all too scant attention. If we wish to develop school spirit we must devote time, energy and money to social activities. *Esprit de corps* does not happen accidentally; it must be fostered.

In order to develop the social side of students they must be given sufficient time to carry on social activities.

The emphasis in the past has been on practice in the wards. It would be well for all concerned if we could strike a happy medium or sort of middle ground policy with our student group. We know it is the social hours in our lives that we cherish, and let us hope we will make more of these precious associations and opportunities for our young women. The time and money will bring abundant returns.

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## WHO WAS HE?

*The following sketch was written by the mother of a student nurse who died during the influenza epidemic. The material was gleaned from the notebook in which the nurse kept a record of her experiences.—EDITOR.*

THE bed was empty when I went off day duty, but it was no surprise to find a "case" in it next morning. We become accustomed to changes as cases come and go constantly in the accident wards. They are part of the nurse's routine.

The new arrival was an old man, apparently of gigantic stature, with a refined and aristocratic countenance. He was asleep. His thick white hair curled on the pillow, one hand was concealed by bandages and splints, the other lay long and white on the bed cover, a hand which indicated clearly that its owner had little acquaintance with the rough hard work which leaves unmistakable traces on the hands of the other ward patients. On the little finger he wore a narrow wedding ring.

He had been found lying unconscious in one of the adjacent streets, and during the night had been brought to the hospital by the police. His left wrist was badly fractured, but he could give no account of the accident. He had lost his memory.

There was nothing on his person by which he could be identified; no papers of any kind, no money, and nothing to show from whence he came or whither he was going. The conclusion arrived at was that he had been robbed of everything, probably knocked down, or fallen in a struggle, thereby breaking his wrist.

For some days I cared for him. He was docile, patient, and never failed to thank me for any attention I showed him; otherwise he remained silent.

It was, I remember, the fifth day after his admission that he raised himself in bed, looked round the ward at the other beds with their occupants, then remarked, "How did I come here? I'm not satisfied with this hotel."

As time passed and he became less helpless, he began to talk coherently at times, though his mind was never clear and little could be gathered from his conversation. During an interval when his thoughts were less vague, I remarked to him.

"You are an Englishman."

"How do you know?" he answered.

"You put your salt in a little heap on the side of your plate. An American shakes it over his food."

"Yes, you are right," he said, with a smile. "I am English, but I have a home in California, an orange farm. I am going there. My sister is there waiting for me."

"Won't you give me her address?" I asked.

He made a rambling reply, giving me but a vague and uncertain address in Somerset, England. Taking advantage of this period of semi-sensibility, I determined to learn as much as I could.

"Have you no wife, no children?" I asked.

"No, no one but my sister," he replied, "I could not live without her."

"But you wear a wedding ring."

"Ah, that was my mother's."

This had been a long conversation, but I gained no information, and he relapsed again into a state of confusion and incoherency. Doctors and nurses alike became interested in this mysterious and nameless patient whom we dubbed "The Duke"—a title suggested by his courtly appearance.

Poor old gentleman—his continual anxiety seemed to

be to get away from his present quarters.

"I must get a better suite of rooms," he would say. "The wine has no body in it and they never bring me cigars when I order them. Kindly bring me my check book."

So frequently did he ask for his check book that to pacify him I invented a subterfuge by giving him slips of paper torn into check shapes, and a pencil. He remained quietly scribbling on the papers for some time, then folded two of the sheets and put them under his pillow. When the doctor on his round stopped at The Duke's bed, the old man drew the two "checks" from beneath the pillow saying, "Take these Sir, one for yourself and one for your assistant. They are only a very slight recognition of all your kind attention to me. Five hundred dollars is nothing for all you have done."

The doctor very tactfully placed the papers, on which no word was distinguishable, in his pocket book, and with profuse thanks and much feeling answered.

"It is a pleasure to attend to you Sir, I assure you it is a great pleasure. Our greatest happiness will be to see you quite well again."

"Nay, nay," replied the old man, "You embarrass me with thanks."

Days passed. There were no inquiries for our patient and no light was thrown on his identity. He was obviously becoming more feeble, heart trouble was detected, and his mind was seldom clear.

On my last day of service in the ward I was troubled at leaving my interesting old patient whom I realized would not long need help. I wished I could remain to the end. I was preparing to go off duty when he called me to him.

"What can I do for you?" I asked.

He looked at me earnestly and recited Poe's lines,—

"Tell this soul, with sorrow laden, if within the distant  
Aiden

It shall clasp a sainted maiden, whom the angels name  
Lenore,

Clasp a rare and radiant maiden, whom the angels name  
Lenore."

He sank again into a state of indifference and, though I tried to reassure him, he seemed not to hear. As I lingered I heard the muttered words, "Victims of a myth?"

I turned to go but he sprang suddenly out of bed exclaiming, "I must leave this hotel at once. I cannot stay here another night. I will go to the proprietor myself and arrange for a better suite of rooms."

Somewhat alarmed by his excitement, I persuaded him to return to bed, promising that if he would do so I would go at once and arrange for better accommodation for him. "For," said I, "I know the wine is indifferent, and the cigars not fit to smoke."

This appeared to satisfy him. He lay quietly while I slipped behind the screen, on the pretence of having gone on his errand, but stayed where I could watch his movements for some seconds. As I thought he was sleeping, he lay so peacefully, I stepped back and looked at him. He had found a better suite of rooms. He was dead.

"Do not talk little on many subjects, but much on a few."—Pythagorus.

If you can't whistle, try smiling.

Ring out old shapes of foul disease.—Tennyson.



## DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,  
Supervising Dietitian, Mt. Sinai Hospital, New York.

### INTARVIN IN THE TREATMENT OF DIABETES\*

BY MAX KAHN, M.D., M.A., PH.D., VISITING PHYSICIAN, DEPARTMENT OF PATHOBOLISM AND DIRECTOR OF LABORATORIES, BETH ISRAEL HOSPITAL, NEW YORK, N. Y.; ASSOCIATE IN BIOLOGICAL CHEMISTRY, COLUMBIA UNIVERSITY, NEW YORK, N. Y.

THE name "diabetes" was given by an ancient Greek physician named Aretaeus. The word in Greek means a "syphon." When one remembers the main symptoms of this disease, one is struck with the aptness of this designation. The diabetic patient ingests huge amounts of water which he is constantly voiding. In certain cases, the individual is simply a syphon tube, constantly taking in and giving out water. It was in the seventeenth century that an honest English physician named Willis, whose sense of duty overcame his sense of humor, tasted the urine of many patients and found, to his astonishment, that a certain number of these urines were as sweet as honey, and he therefore called this condition *diabetes mellitus* in contradistinction to the excessive excretion of water which had no sweet taste and which was called *diabetes insipidus*.

#### Chemical Disturbance of Diabetes

Diabetes is a disease characterized by chemical disturbance in the human body which manifests itself in the inability of the body to burn starchy or sugary foods to carbon dioxide and water. This chemical functional incapacity gradually becomes more complete until the quantity of carbohydrate food that can undergo combustion in the body is very low indeed. The patient, therefore, though seemingly taking in a lot of food-fuel, loses weight; for the starchy foods pass out of his system unused. The overloading of his blood with unoxidized sugar causes an extreme thirst accompanied by micturition of large quantities of water. These two symptoms, together with his excessive hunger and his marked loss of weight are the main complaints of diabetic individuals.

What is the cause of diabetes mellitus? Most likely there is a multiplicity of causes. If we look at the figure on the following page we shall see what a distinct interrelationship there exists between the various organs having to do with the various phases of carbohydrate metabolism.

#### Relation to Pancreatic Function

A relation between diseases of the pancreas and diabetes had long been suspected, but Minkowski and Mehring first definitely showed that complete removal of the pancreas in the dog, cat, and pig, is followed by diabetes having the usual symptoms of that disease in man. That this

is caused by the absence of an internal secretion is proved by the fact that it does not occur if the gland be left *in situ* and the duct tied; nor does it occur if a portion of the pancreas be grafted in some situation remote from its normal position (e.g. underneath the skin or in the peritoneum). How the internal secretion of the pancreas normally prevents glycosuria is not clear. We can only say that it exerts some influence upon the carbohydrate metabolism, either by favoring the formation of glycogen in the liver from the glucose taken to it by the portal vein, or by furthering the oxidation of glucose in the tissues generally.

In the wake of the intolerance for starchy foods that the diabetic evinces, there follows a disturbance in the assimilation of the fat foods, which derangement is still more dangerous to the patient.

How do fats break down in the body?

It was shown by Knoop in 1905 that fatty acids in combination with aromatic radicals when given to animals are oxidized in a definite manner in the animal organism. It is known that if benzoic acid is administered by mouth it is excreted in the urine, in conjunction with amino-acetic acid, as hippuric acid. Phenylacetic acid is eliminated as phenaceturic acid.

If a higher acid than acetic acid is administered the resultant product eliminated is either the hippuric acid or the phenaceturic acid, depending upon whether the side chain was of an odd or even number of carbon atoms. Knoop, therefore, concluded that in the oxidation of fats the beta-carbon atom was oxidized and that two carbon atoms dropped from the chain together.

In the catabolism of fats under normal conditions, (that is, in the presence of proper carbohydrate oxidation) there is a rapid break down of the fatty acid radical to the four-carbon acid, i.e., butyric acid. The butyric acid is then rapidly catabolized to carbon dioxide and water.

This process, however, is markedly disturbed in states of deficient carbohydrate oxidation. In the latter circumstance, the fats are primarily broken down to butyric acid, as in the normal condition, but in the absence of the heat of carbohydrate, but this is not quite right, inasmuch as of the butyric acid proceeds very slowly. The butyric acid under these conditions is decomposed first to beta-oxy-butyric acid and then to aceto-acetic (or diacetic) acid. The further decomposition to acetone takes place very largely in the urine itself.

\*Read before the scientific faculties of Columbia University, February, 1924.

Rosenfeld has said that fats burn only in the fires of carbohydrates, but this is not quite right, inasmuch as only the breakdown of the lowest products of fat decomposition, that is to say, the acetone substances, depends upon the catabolism of the carbohydrates.

Embsden has found that only fatty acids of an even number of carbon atoms will yield aceto-acetic acid in the transfused dog's liver. In this way from stearic acid ( $C_{18}$ ), palmitic acid ( $C_{16}$ ) is formed; from this an acid with 14, 12, 10 or 8 carbon atoms is derived. Then caproic acid ( $C_6$ ) and, finally, butyric and oxybutyric acids are formed.

Several years ago I endeavored to see the effect of the feeding of a fat containing an odd carbon fatty acid.

Collaborating with Dr. H. O. Nolan, we succeeded in preparing an odd carbon fatty acid fat that is edible, is absorbed to the extent of about ninety per cent, is catabolized in the body and does not yield the ketone substances derived from butyric acid.

The method of preparation is as follows:

Stearic acid has its acid group substituted by an organic radical and upon oxidation with a strong oxidizing mixture the  $C_{17}$  acid ( $C_{16}H_{33}COOH$ , margaric acid) is produced. This is easily purified and then united with glycerol to form a neutral fat. This fat, when well prepared, is of a white creamy color, odorless and tasteless, melting at  $38^{\circ}C$ . and neutral in reaction. When cold and granulated it is quite palatable. It does not cause any sense of nausea, it seems to satisfy the craving for fat that diabetics have.

### Ways of Administering by Mouth

The fat is administered by mouth in the following ways: (1) granulation of the fat and direct consumption with the aid of salt, pepper or vegetables; (2) baking with the fat; it was used in the preparation of Lister's bread, etc., (3) frying with the fat after "rendering" it with onions; (4) in the form of an ice-cold emulsion in buttermilk, etc.; (5) in the form of a flavored drink; (6) with hot drinks, such as coffee, broth, etc.

The quantity given varies. The patient, for example, can tolerate, of carbohydrates, proteins and natural fats, a total intake of 1,500 calories daily without the excretion of glucose or acetone in the urine. To this patient, one can give, say, ninety grams of intarvin and thus increase the caloric intake to 2,250. Intarvin may be given in conjunction with insulin, but it is especially indicated in the non-severe diabetic individuals, in whom dietetic regulation rather than insulin is the proper method of treatment.

Dr. Joslin writes as follows: "Furthermore, it can logically be recommended to those cases with whom the fat-carbohydrate ratio is above 3:1. Indeed that might appear to be an arbitrary rule for its employment and perhaps in the course of time one may change this rule to the use of intarvin whenever the patient's fat-carbohydrate ratio must be raised above an even lower ration in order to maintain nutrition."

Intarvin is easily absorbed. Analysis of the feces of a normal individual showed five per cent loss, indicating in that case an absorption of ninety-five per cent. In general, the absorption varies between ninety and ninety-five per cent.

It is non-toxic and is capable of sustaining life like natural fat. Experimenters at Columbia University have substituted this fat for natural fat in feeding experiments on rats. The rats behaved normally, their weight increase did not vary from the controls. They gave birth to new litters of rats who again were fed this fat. In this way four generations of rats, all normal and all behaving normally have thus far been reared.

When intarvin is administered to phloridzinized dogs, it is excreted as glucose. This is in confirmation of the work done by Ringer and others. They have repeatedly reported that the feeding of an odd carbon fatty acid to a phloridzinized dog is excreted as glucose. The acid is broken down gradually to the  $C_3$  acid (propionic acid) which is then converted to glucose.

The conversion to glucose does not take place in diabetic individuals, again demonstrating the great difference between phloridzin glycosuria and true diabetes.

The conversion to glucose does not take place in diabetic individuals, again demonstrating the great difference between phloridzin glycosuria and true diabetes.

Experiments are now under way to see how intarvin is stored in rats, dogs and other animals, and what effect it has on the composition of the body fats, especially brain fat and the lecithins. The field is rather large and will require many workers and much time to answer the very many purely chemical and speculative philosophical questions that arise.

A well known metabolist draws the following conclusions from his experiments on intarvin. I shall conclude my paper by quoting these sentences:

- (1) Intarvin, unlike natural fat, may be used in the diet of a severe diabetic patient without fear of acidosis.
- (2) The substitution of natural fat for intarvin in the amounts used in the experiment promptly brought on an alarming acidosis.
- (3) The above severe acidosis was promptly relieved when the intarvin was restored to the diet.

### HOSPITAL DIETETIC COUNCIL TO MEET

The second annual conference of the Hospital Dietetic Council will be held in conjunction with the twenty-sixth annual conference of the American Hospital Association at Buffalo, N. Y., October 6-10, 1924. Further announcement concerning the meeting will appear in the October issue of THE MODERN HOSPITAL.

### HOT THINGS HOT, COLD THINGS COLD

If comfort you would give your whole household,  
Serve hot things hot, and cold things cold.  
The lukewarm habit to none is fair,  
It soaks into the system too much "don't care,"  
So, mothers, look well to the household ways,  
By heeding the injunction given of old,  
Have hot things hot, and cold things cold.





## SOME PROBLEMS OF THE DIETARY DEPARTMENTS OF SOUTHERN HOSPITALS

BY UNA M. CRAWFORD, DIETITIAN, BAPTIST HOSPITAL OF FORT WORTH, FORT WORTH, TEXAS.

**T**HERE is no place more devoid of the refinements of the outer world than an unorganized dietary department in a southern hospital. It takes a broad vision and a lot of dreaming to live over the present for the accomplishments of the future.

It takes all the womanhood, all the tact that one has reserved to tackle a position where colored help has reigned supreme for many years; where the people feel that the kitchen, regardless of science, belongs to the "nigger mammy," and where she and her followers are of the same opinion. Being a southern girl, I knew what was awaiting me and I knew that I could handle by colored help better than I could tackle white supervisors of southern birth, for a negro can scent intelligence as easily as he can a "lady or gentleman" (an extra sense that the Lord has given them) and they like to show their appreciation of a "queen of the pantry." Deep in the negro heart there is the desire for some one to teach him system.

### Doctor Prefers Mammy to Dietitian

In the four years I have been in southern hospital work, I have seen the dietitian coming into her own every year by her constant demand of her rights as a college trained woman. I heard a good southern doctor say one day that he would much prefer a good colored mammy's cooking to any scientific dish a dietitian might suggest. That is just the point. He had no idea of the duties of the head of a dietary department. Another doctor said that a dietitian was a luxury. Possibly so, but not from a financial viewpoint, where one-fourth of the food is carried off by the help each evening, where enough food is left over to feed another hospital of the same size, where the food is not stored properly and is eaten up either by mice or cockroaches, and the whole hospital personnel goes away from the table unsatisfied, possibly not from lack of food, but from the poor service and lack of variety.

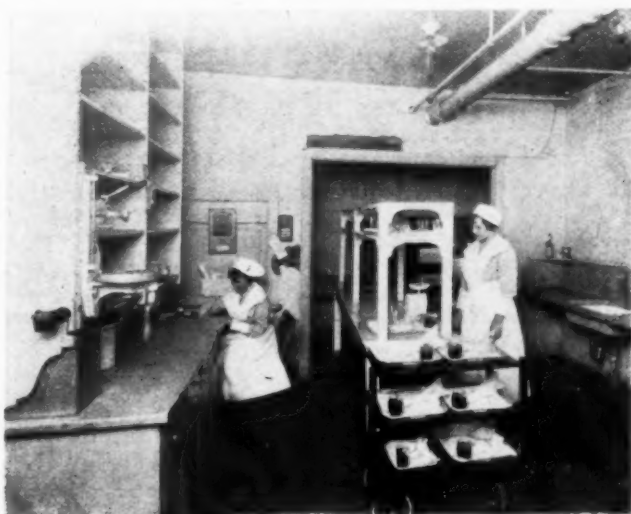
Such was the problem found by a dietitian in a hos-

pital in the extreme south. The first month she was there she saved in the grocery bill alone four times her salary, gave a pleasing diet of variety according to the season, and was told by one of the chief surgeons in the hospital that she had changed the morale of the student body. The wife of the president of the board was a patient in this hospital for several weeks and went home delighted. In a short time one of the members himself was brought in as a patient and left the hospital with a satisfied feeling in his stomach. Then it was the good luck of this dietitian to minister to one of the doctor's brothers, a senator who was having special diet treatment, and he was pleased. Thus, one by one the ideas in regard to the value of a dietitian were changed. The whole town was pleased. The ladies' auxiliary soon had its first meeting and the dietitian decided that she would surprise them also, so with her own hands she worked all morning over some dainty sandwiches of many shapes and kinds, and concocted a punch such as they never tasted. Suffice it to say that they went home in wonder. After that when they entertained, she was called upon for suggestions.

The nurses who had hitherto dreaded their diet kitchen work, looked forward to it, for it was here they learned that science and practical work went side by side, that with their heads and hands many lovely things could be done which they had before considered just stuff. While the department was steadily progressing this dietitian left one day for a bigger place and bigger problems; but she left the hospital and the town with different ideas of the ability of a dietitian.

### What One Dietitian Did in a Year

Another dietitian I know tackled a position in a hospital where it was her duty to organize a dietary department. The word organization is a great big word, but when the capital is limited and the hospital is new and needs that "limited capital" in so many other places,



Main diet kitchen where all cold foods are put on trays and all liquid nourishment and special diets are prepared.



Main kitchen adjoining diet kitchen where all hot foods are put on trays and where food for all hospital personnel is prepared.

it is then that this word organization takes on another aspect. But this young woman had been trained in the school of patience and hard work. The first thing she did was to line up the best people to buy from, and to become acquainted with the wholesale houses both for groceries and equipment. Then began the task of having a system for the best possible service for the conditions that existed at that time, for hungry people could not wait for a dream to materialize. After the first month of hard effort to straighten out the bills, she had reduced her expenses about \$300, and then she was allowed one thing at a time that she needed. Within a year and a half, she had a well-run central system and an organized corps of help, the cooperation of the training school superintendent, the respect of the board of managers, praise from the patients and a well-fed hospital personnel. This was eighteen months of the hardest work she had

ever done, and it required the elimination of a number of the help who had been in the hospital under the old regime, but this step was necessary and they had to go. A short time ago the writer visited this dietitian, and found her very happy in her present accomplishments, and she is now working toward many other things she needs.

The dietary field is a big one and we need women who go into it with a desire for creation and a love for their work. As in all successful callings, we must have young women who have a dream ahead, and an ambition for the institution in which they are working, for the hospital, as the army, "works on its stomach." She must be happy and by all means must not be a "scraper." If we all think success thoughts and work with a song in our hearts, many of our present difficulties will be memories, and we pioneers will reap the harvest which comes from our great efforts.

## PLANS FOR DIETETIC CONVENTION MATERIALIZE

**P**LANS are in full swing for the seventh annual convention of the American Dietetic Association to be held at the New Ocean House, Swampscott, Mass., October 13, 14, 15 and 16, 1924.

The extensive nature of the convention program will be invaluable to dietitians in all phases of the nutrition field. Monday morning, after the meeting has been opened by the president, Octavia Hall Smillie, Amalia Lautz, president of the Massachusetts Dietetic Association, will extend greetings and also Dr. Alice F. Blood, former presi-

dent of the home economics association. A speaker of outstanding note, whose name we are not yet at liberty to reveal, will start the Monday morning meeting. Plans for the symposium luncheon are coming along splendidly, so that Miss Katharine Fisher will be able to announce the list of speakers in our next bulletin. Breakfast and luncheon hours are to be utilized for informal group discussions of our many problems.

The sections will meet as follows: Administrative, Monday at 2 p. m.; education, Tuesday at 10 a. m.; dieto-

### BULFINCH BUILDING, MASSACHUSETTS GENERAL HOSPITAL



In the dome of this building, ether was first used as full surgical anesthesia, October 16, 1846. Since September, 1821, the hospital has had an enviable record of service. The main buildings, Phillips House, private pavilion, eye and ear infirmary, McLean Hospital for the insane have facilitated the treatment of every imaginable suffering to which mankind is heir.



therapy, Tuesday at 2 p. m.; social service, Wednesday at 10 a. m.

Monday evening Dean Annie Goodrich, Yale University School of Nursing, and Dr. M. T. MacEachern, president, American Hospital Association, and director, hospital activities, American College of Surgeons, Chicago, Ill., have consented to speak at the dinner meetings. We are also fortunate in having Dean Edith Tufts of Wellesley College and Dr. Daum of the Presbyterian Hospital. Dr. Abraham Myerson of Boston will discuss problems of diet in the care of nervous patients. Dr. Percy Howe of the Forsyth Dental Infirmary, Boston, will consider the relation of feeding to dental development.

Two types of exhibits are planned, commercial and non-commercial. The commercial exhibits mean much to the dietitian who does not buy and yet must keep in touch with the progress in this field in order to requisition intelligently for the needs of her department. They are becoming more valuable each year and no member would think of leaving without seeing the products and discussing their merits with each firm's representatives. This convention will see the beginning of our permanent non-commercial exhibit. It is to be hoped that dietitians will not overlook this opportunity for comparing methods and forms used by hospitals, dispensaries, commercial firms, and social service workers throughout the United States and Canada.

#### Thursday Morning Reserved for Trips

Thursday morning, October 16, has been reserved for trips of professional interest to dietitians. These should be considered as an essential part of the convention program where one may see the problems and developments which have been discussed the previous days, either solved or in operation.

The following list of hospitals is on the visiting schedule:

Children's Hospital, orthopedic, surgical and medical work; Deaconess Hospital, Dr. Joslyn's Clinic for Diabetic Patients; Harvard Medical Court Yard and Library; Peter Bent Brigham Hospital, medical and surgical departments; Massachusetts General Hospital, Phillips House, out-patient department, and Eye and Ear Infirmary.

Industrial lunchrooms are available at the following concerns: Federal Reserve Bank, New England Tele-

phone and Telegraph Company, and Print Works Cafeteria of Pacific Mills Company, Lowell.

The following hotels and clubs will be open to guests: Copley Plaza Hotel; New Ocean House; Women's City Club; and the Boston Chamber of Commerce.

Commercial lunchrooms of interest are:

Boylston lunch department of Women's Education and Industrial Union, Filene's Restaurant, Food Shop of the Women's Educational and Industrial Union, New England Kitchen, and Schrafft's Restaurant.

#### PETER BENT BRIGHAM HOSPITAL



The first patient was admitted in January 27, 1913. During 1913, 1,370 patients were admitted. Four thousand seven hundred and seventy-five patients were admitted during 1923—4,159 more days' treatment than in any previous year. The Peter Bent Brigham is noted for its medical and surgical services backed by very efficient nursing, and for the results secured in the dietary department.

Colleges and private schools accessible are:

The Choate School, Dana Hall, Lasell Seminary, Simmons College, and Wellesley College.

Public school lunch rooms of interest to dietitians are the Boston School Lunch Central Kitchen and Boys' and Girls' Latin Schools, Brookline High School, and the Newton Junior High School.

Places of interest for nutrition workers are Carnegie Nutrition Laboratory in charge of Dr. Benedict, Food Clinic of Boston Dispensary, and Forsythe Dental with talk by Dr. Percy Howe.

Ample time will be given and provision made for visiting historical Boston, Lexington and Concord. Here one may see the Old North Church where Paul Revere hung his lanterns. April 18, 1775. Old South Meeting House was built in 1729.

Convention headquarters at the New Ocean House are ideal in every respect. All members will be accommodated in spacious attractive rooms. The view of the ocean upon awakening in the morning and the twang of the breezes as they blow in from the water will start the day with a zest for the meet-

(Continued on page 274)

#### CHILDREN'S HOSPITAL



We here find the only hospital in the United States devoted entirely to the care of children with all three services, medical, surgical and orthopedic represented under one management. The loyal support of the hospital's uninterrupted service to the children since 1869 has demonstrated the pride of Boston's people in her outstanding Children's Hospital.

## FIRE PREVENTION DEPARTMENT

Conducted by W. M. Krieger, Engineer,  
209 West Jackson Boulevard, Chicago, Ill.

# HOSPITAL FIRE HAZARDS FROM THE VIEWPOINT OF THE FIRE-PREVENTION ENGINEER

**I**N THE August editorial announcing the new fire prevention department, the editor again referred to the Chicago State Hospital fire which occurred December 26 of last year. For the purpose of impressing those responsible for hospitals, we desire to quote from "The Fire Plug," an estimable little paper devoted entirely to fire prevention:

"Behind this blazing frame wall, lie the roasting bodies of *nineteen persons*, most of them inmates of the Chicago State Hospital for the mentally ill at Dunning. What a holiday spectacle for the night following Christmas!

"As the investigation starts, a number of conflicting statements concerning the condition of the premises prior to this shocking tragedy are being made. This picture is indisputable proof that the building was nothing but a flimsy fire trap.

"This was the seventh fire in the institution in thirteen years! Probably necessary improvements in the remaining buildings will now be made, but what about the nineteen lives snuffed out?

"It is again proved that hospitals should be absolutely fireproof, and under any other circumstances should be equipped with automatic sprinklers."

### Fire Prevention and Insurance

Benjamin Franklin has much to his credit aside from his ability as a newspaper man and a kite-flyer, for he was a potent factor as a fire preventionist and also an organizer of a fire department. In describing the organization of the Philadelphia fire department he is quoted as having said:

"Our articles of agreement obliged every member to keep always in good order, and fit for use, a certain number of leather buckets . . . which were to be brought to every fire: and we agreed to meet once a month and spend a social evening together, in discoursing and in communicating such ideas as occurred to us on the subject of fires."

Fire prevention, as a thought, started here and has since grown into a science, but it can no more be separated from fire insurance than can the modern hospital be separated from its doctors, surgeons and nurses.

The necessity for the preservation of life is the justification for doctors, surgeons, nurses and hospitals.

The great fire insurance companies must constantly seek means for the prevention of fires and through long years of investigation have developed their schools and

laboratories for the doctors and surgeons of fire prevention who receive the degree of fire prevention engineer.

Some thoughtless persons have made the statement that fire insurance companies are not concerned as to losses. It would be about as absurd to say that doctors and surgeons are not concerned as to the life of their patients. If all insured property, or even a considerable percentage of it, should burn, no insurance company could survive, nor could the medical profession successfully exist if its physicians and surgeons had no desire to produce cures and preserve the lives of human beings.

It is regrettable that the public generally is not informed as to the great service, aside from loss payments, rendered by fire insurance companies. In future articles we will describe some of the activities of insurance companies in this direction.

THE MODERN HOSPITAL has consistently advocated increased hospital facilities of substantial construction, but if we neglect to advocate adequate protection of those already constructed against the ravages of the fire demon, we will find our purpose defeated.

The public must be made to realize that the hospital is safe. The patients have enough to worry about in their own ailments without concerning themselves as to the danger of fires.

### Hospital Fire Tragedies Must Cease

The final decision as to the cause of the Dunning fire was, "oil floor mops or defective electrical wiring." If the former were the cause, there is nothing to say but "carelessness"; if the latter, it could have been corrected; this was nothing less than "neglect."

Can a fire occur in the hospital for which you are responsible by "carelessness" or "neglect?"

Do you know the causes of fires? Do you know how to treat fire hazards?

Has not your experience in hospital work demonstrated the value of the x-ray and of the careful diagnostician? Would not this experience warrant you in consulting the specialist on fire prevention to determine the best method of treating the fire hazards of your properties? If so, you are given the opportunity to avail yourself of the services of THE MODERN HOSPITAL's fire prevention department.

Stop these tragedies! Build more hospitals? Build them to live,—not to burn! Protect those now built by



following the recommendations of our fire prevention engineers.

We offer this service to your property without cost or obligation on your part:

**New buildings:** The engineers will examine your plans and consult with your architect, pointing out any features which will tend to lessen the fire hazard and secure the lowest insurance rate consistent with the construction and equipment contemplated. You will be advised in advance of the criticisms which would follow faulty construction, by the underwriters supervising the section where you propose to build.

Recommendations will be made as to the fire fighting equipment essential for the property and many other features which can easily be corrected in your plans, and which, if not corrected in advance, may produce great expense and constantly higher insurance cost for years to come.

**Old buildings:** The engineers will make a personal inspection of your properties, pointing out in a confidential report to the proper authorities, those defects which tend to increase the danger of fires. They will give you the benefit of their judgment as to the easiest and least expensive way of eliminating these dangers.

They will inform you as to the charges made by insurance raters for any faulty condition, and may often, through your own insurance agents, secure a reduction in your fire insurance costs for improvements easily made.

**Fire fighting equipment:** This will be examined and if found defective you will be informed of its condition and advised how to correct defects. You can take counsel with this department by mail on the efficiency of any fire fighting appliance which you propose to install. We will not recommend any appliance which has not been able to stand a proper test of its efficiency and reliability.

**Insurance:** The engineers in this department are thoroughly experienced in all insurance matters; they will examine your insurance policies, consider and advise you as to the forms, the coverage, clauses and the obligations you are required to assume under the policy contracts. They will prepare forms not in conflict with the underwriting rules of your territory and, when necessary, assist your agent in securing approval of new forms.

**Rates:** We will, when requested, examine the "make up" of your insurance rate and, if possible, suggest improvements in the fire hazards of your risk which will tend to bring the cost of this considerable item of expense to the lowest premium consistent with the kind of construction and protection found in your property.

**Our service department:** This department is organized for the purpose of counsel and advice to hospital authorities on all subjects pertaining to prevention of loss of lives and property by fire and casualties, including the furnishing of information as to all kinds of insurance obtainable which is intended to indemnify the trustees in the event of loss.

It is not the intention of THE MODERN HOSPITAL to engage in the insurance business; on the contrary, we believe in the principle of supporting the local agencies in each community, and it will be the purpose of this department to extend its fire prevention work and insurance information service to hospitals without interfering with their present agency arrangements and without charge to either.

We are, however, believers in the statements that "good insurance is not cheap," and that "cheap insurance is not good."

We wish to impress upon every man and woman in

charge of hospital property that they, as trustees, are at least morally responsible for its upkeep and for the removal of any hazard which unnecessarily subjects the property and lives of the patients to danger or destruction.

Hospitals, as a rule, are conducted with funds voluntarily contributed by individuals or derived from taxation. If you should fail to correct dangerous conditions brought to your attention, or neglect to provide adequate and reliable insurance sufficient to replace the property in the event of catastrophe, you will have been remiss in your duties as trustees. This will make it difficult to interest those accustomed to the greatest foresight in such matters, in making substantial contributions to future hospitals. They will fear that the funds contributed may mean only the purchase of an ash pile, and thus fail to serve the great cause of humanity.

The following information will no doubt be of service to some of our readers, and will impress them with the seriousness of the fire loss situation, even should they not avail themselves of our services:

The question of proper exits justifies us in quoting from the work of H. W. Forster on fire protection for hospitals.

"It is difficult enough to secure adequate egress facilities in factories or other buildings where the occupants are physically fit and mentally competent. The problem in buildings housing the sick and the incapacitated is infinitely harder. The conditions in institutional buildings generally are bad, frequently deplorable.

"The reason the loss of life is not greater than it is, does not lie in good buildings, adequate exits, good alarm systems, adequate fire protection and trained staffs, but in the fact that such buildings are used continually and fires are likely to be discovered in their incipency, and in that nurses and other attendants have shown remarkable heroism at times of crisis."

Do not trust to the transfer of your patient in an emergency from a hospital bed to a stretcher but see that the door is large enough to permit the bed to pass through without the transfer of the patient.

It would be possible to devote a great deal of space to this one feature of safety, which is of even greater importance in the building not entirely of fireproof construction. It is a subject which engineers stress strongly in their reports. Proper cut-off of anesthetizing rooms so that gases may not reach open lights or fires, is most important.

Volatile liquids are fire hazards. Keep the main supply out of the building or in fire-resistive vaults having proper ventilation and drainage. Try and avoid having such supplies in the wards except in the smallest quantities.

Install vapor-proof lamp globes in anesthetizing, operating and laboratory rooms.

Dangerous or explosive chemicals should be carefully labeled and kept under lock.

Organize a fire brigade among the hospital attachés.

These are only a very small number of important features investigated in our inspection service.

We wish to commend especially the work being done under the direction of the fire prevention department of the Western Actuarial Bureau, an organization supported jointly by all of the fire insurance companies and from whose reports and figures we have secured valuable data. The figures and cautions of the National Board of Fire Underwriters, and the splendid recommendations of the National Fire Protection Association, should receive the greatest consideration from every one responsible for hospitals. In future articles we shall quote liberally from documents obtained through these channels.

## HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent  
Michael Reese Hospital, Chicago, Ill.

### CUTTING A HOSPITAL'S COSTS FOR HEAT, LIGHT AND POWER

By C. H. SCOTT, GENERAL ELECTRIC COMPANY, LYNN, MASS.

**S**TATISTICS indicate that of approximately 600,000,000 tons of coal annually consumed in this country for all purposes, sixteen per cent or 96,000,000 tons are used for heating.

While authentic figures are not available to show segregated coal tonnage required for hospital and sanatoriums, if we bear in mind that 6,762 of such institutions with a total bed capacity of 770,375 are in existence with new institutions being added at a rate of approximately 200 a year, it is evident that the annual drain on the nation's coal pile for such institutions represents a large tonnage.

The writer, having assisted in carrying through a "power economy" campaign in a 135 bed hospital serving a city population of approximately 100,000, presents herewith, certain data demonstrating of betterments which were secured. The inference to be deduced is that if in an otherwise generally well-conducted institution such "leakages" could occur, there are in all probabilities other institutions offering similar opportunities to effect savings.

This article will touch upon a number of features which burden the debit side of the hospital ledger. While no two cases will be found amenable to the same treatment, yet certain "correcting factors" used in the instance chosen may also apply to a sensible percentage of existing hospitals, especially of the less modern type.

#### Coal Bill Reduced Thirty-nine Per Cent

We are to describe a hospital buying central station energy for light and power and using coal-fired boilers for various steam purposes. It is, perhaps, hardly to be expected that the small steam plant can or will be given the same careful scrutiny in original layout or subsequent operation and upkeep as that of the larger plants which are justified in maintaining a higher grade staff of mechanical and electrical technicians. In this particular case the methods used to cut coal costs required quite simple corrective measures, and the results secured are somewhat illuminating as indicating the sum total secured through small savings. The coal consumption for the year preceding the "economy campaign" was 1,466 tons. Three years later through gradually effected betterments, the annual coal bill dropped to 881 tons, a reduction of thirty-nine per cent.

These results were secured largely as follows:

(1) Proper protection against heat radiation by jack-

eting of boilers, hot water heaters, main valves and all live steam and hot water piping.

Uncovered piping represents an important fuel loss. Depending upon temperature, movement and humidity of surrounding air, cost of fuel, etc., each uninsulated square foot of piping penalizes the coal pile to an amount varying between \$1 and \$2.50 yearly.

(2) Replacement during summer season of original four-inch steam mains, (tunnel installed between detached power house and hospital buildings. These mains had been energized during the warm months simply to heat steam tables and sterilizers. The use of a one and one-half-inch feeder provided ample steam for the required purpose and avoided previous radiation losses in the main steam line.

(3) Installation of automatic hot water faucets. It is seldom appreciated that a single hot water faucet running continually at full opening may cost close to \$1,000 yearly. This condition may be found where a number of leaky or carelessly guarded faucets will in total be equal to one faucet operating at full opening.

#### Economy in Removal of Night Fireman

The custom had previously existed of keeping a night fireman to run the single boiler used during the warmest period of the year from June 15 to September 1. It was found that if this single boiler were banked at 10 p. m. sufficient heat would be provided until 6 a. m. of the following morning for ordinary hospital uses, thus making possible the elimination of the night fireman, also the saving of considerable fuel. Auxiliary gas stoves are available for water heating, should extra needs arise.\*

(4) The replacement of a 10 horse power steam engine by an electric motor of similar rating, (recording watt meter tests subsequently taken showed that a 7.5 horse power motor with its momentary overload capacity of 50 per cent would have handled the maximum load.) As the governor was in practically inoperative condition, the engine consumed an inordinate amount of steam. In cold weather it was often necessary to throw in the third boiler simply to provide steam for the engine. The shift

\*To obtain annual benefits arising from hourly economies, the rather obvious point may be accentuated that to heat at any time when heat is not needed, costs money. Hence, unoccupied rooms or departments should have the heat shut off.



over to the central station power saved the entire cost of the change in less than a year, but showed a large continuous benefit in operating cost.

(5) Careful repair and continual checking to keep in repair all steam and hot water valves, steam traps, joints, couplings etc. The average small plant owner or operator seldom stops to consider the accumulative losses from small sources. For example, at 100 pounds steam pressure, openings totalling one thirty-second of an inch in diameter may cost \$35 per year in wasted fuel.

(6) Rehabilitation of defective steam traps and substitution, where necessary, of new apparatus. This is an important focal point for economy, since a number of leaking steam traps causes serious annual waste.

Practically all main steam and subsidiary valves in the high pressure line were found to be in a more or less defective state. During the summer months a 250 foot four-inch line, although supposedly closed, had been partly energized through a leaking main boiler valve. A six-inch valve reseating machine was thus purchased.

### Careful Weighing Aids Saving

Coal had in the past been ordered without any particular supervision or record. Scales were installed, a careful record being thereafter kept of day-to-day consumption. This log and similar logs maintained for metered central station energy enable ready checking against any abnormal rise in consumption. Thus, if seasonal conditions are normal and coal consumption runs up, an investigation and subsequent correction are at once made. If coal shows indication of deficiency in proper heating units, excess of impurities, etc., a test is made to validate complaint against the coal purveyor.

Before the above economies were initiated, cold weather demanded constant use of three 90 horse power boilers, often with auxiliary forced draft. Two boilers without forced draft now provide steam in excess of all requirements in the coldest weather.

Often new steam equipment is added when what is needed is simply to stop the leaks. Success in keeping down unnoticed but sensible annual drains on the coal pile can also be obtained by throttling down the steam supply at the mains during mild days and shutting off radiators when not needed. How often may one see windows opened to cool off a room while steam is left at full opening! Care should be taken in freeing steam lines from condensation. Water clogging not only requires excess pressure to carry steam to line ends but produces aggravating and snapping noises particularly undesirable in a hospital. It is also suggested that careful attention be given to door and window air leaks. The use of weather strips and double windows are thus frequently a paying investment. Thermometers should be generously used throughout a hospital. Their first cost is negligible and of course they tell at once when to shut off or turn on steam. Thermometers should be hung where they will register average temperatures, that is not too near doors, windows, or radiators. Have all radiator valves in good working order,—stems straight, seats tight and gripping wheels intact.

### How Lighting Bills Were Reduced

Our hospital lighting bills were quite drastically cut through the following methods:

(a) Elimination of obsolete fixtures as, for example, opaque metal bowls each equipped with six 60 watt lamps illuminating by reflected light were replaced by

modern fixtures, each lighted by one 75 watt "gas filled" lamp. The distribution and quantity of light showed improvement over the previous 360 watt fixtures. Twenty-four 60 watt ceiling lamps also with opaque bowls used in private wards were also replaced by 10 watt lamps per fixture.

(b) A careful check on candle power on lamps used that light might be adequate but not wasted. Sixty watt and in one case a 100 watt unit were used in stairways, store rooms, etc. These were replaced in practically all cases by 10 watt bulbs.

(c) In the hospital described, electric irons were fed from the 110 volt lighting circuit at about seven cents per kilowatt for night current and five cents for day current. The heating units were changed to 220 volts with a resultant drop in KWH charge to three and eight-tenths cents. Where insurance regulations so demand, the 110 volt irons may be perpetuated, a transformer being installed to step down the voltage from 220 to 110 volt. This arrangement has a slight advantage due to longer life with 110 volts heating units, partly offsetting the transformer losses. In the case cited it was judged more profitable to use current from 220 volt power lines and the result both in operating cost, and life of the heating units themselves has in every way been excellent.

(d) A check on voltage throughout the hospital showed that 110 volt lamps required change to 115 volt. This change resulted in a double saving, first on lamp life, second on bills for current.

(e) Lock sockets were installed in basements and other unguarded locations resulting in longer "permanence" of bulbs.

Despite additions of new lamps here and there, the largely increased use of fans, the installation of a few small motors on the lighting circuit, the lighting bills were reduced in three years by nearly 40 per cent.

### Economy in Shutting Off Power

Despite sensible additions to load which were due to installation of 10 horse power laundry motor; to shift over of laundry irons from 110 volt lighting circuit to 220 volt power; a practical doubling of daily ice supply, the addition of fans, etc., the total kilowatt consumption was only increased 1,300 kilowatts yearly. The total connected motor load is small, that is, 10 motors aggregating about 40 horse power. The relative economy on power circuit has been quite largely due to care in shutting off power when not needed.

The refrigerating plant offered a good opportunity to save dollars and give better service. Refrigerating chambers, ice tanks, cooling room for fruits and perishable vegetables were re-insulated and subjected to a general overhauling. The cubical content of various cooling chambers was reduced, still leaving adequate space for the purposes required. The making of ice was put on a standardized basis, that is, blue printed fill-in blanks were prepared, enabling operatives to draw ice following a predetermined method of rotation, thus preventing the unnecessary uncovering of tanks and the pulling of blocks only partly frozen.

In summary, the economy campaign at the institution in question resulted in a saving of approximately 35 per cent on the total bills for coal, labor, supplies and electrical energy; these results being obtained within a period of about three years.

In the last thirty years, progress in medical and surgical skill with improved design and enlarged adaptation

of equipment has reduced the time of the average patient's hospital stay approximately 30 per cent. Electricity in many ways has materially aided towards

such results and it may be expected that the best practice will more and more demand that nothing which can be done electrically be left to less efficient methods.

## AN AUTOMATIC INVALID LIFTER

By ROBERT EMMETT FARR, M.D., SURGICAL CLINIC OF MINNEAPOLIS, MINNEAPOLIS, MINN.

**H**ISTORY relates that, from the earliest times, efforts have been made to devise means of lifting and transporting those who are confined to bed in institutions. A careful review of available literature and an examination of the drawings of devices which appear in the patent offices at Washington fails to reveal an instrument that meets the requirements with any degree of adequacy. Devices have been produced which meet some of the indications most admirably. All, however, are woefully lacking in versatility and unfortunately those which present the greatest degree of adaptability are cumbersome, expensive, difficult to manipulate and complicated in their structure.

One notes in the modern hospital the almost entire absence of apparatus of this nature excepting the ordinary stretcher, a fact which most eloquently attests the inadequacy of other available apparatus. The conveyance of the helpless patient from bed to bed, bed to stretcher, stretcher to operating or x-ray table, is carried out almost universally through the agency of nurses and attendants who lift patients manually to the stretcher. While this method is efficient, speedy and most satisfactory for the unconscious patient or for one who can be moved without injury or the production of pain, it is often contra-indicated in the case of those who are extremely ill and those in whom undue manipulation might cause pain, trauma, or the dissemination of sepsis.

It is frequently desirable to elevate patients from the bed and often necessary to transport them to some other portion of the institution. In carrying out these procedures it is also desirable to avoid pain, local or general bodily injury, and in many instances it is imperative to make the transfer with the slightest degree of modification of the relation of the patient's limbs and trunk to each other. Quite obviously these details cannot be satisfactorily fulfilled by the ordinary methods which are now in use.

In developing the automatic lifter the writer has endeavored to meet the above mentioned indications and

in so doing he has kept constantly in mind the necessity for producing an apparatus of simple construction, moderate expense, ease of manipulation, versatility and wide application.

The instrument has been so designed as to occupy the

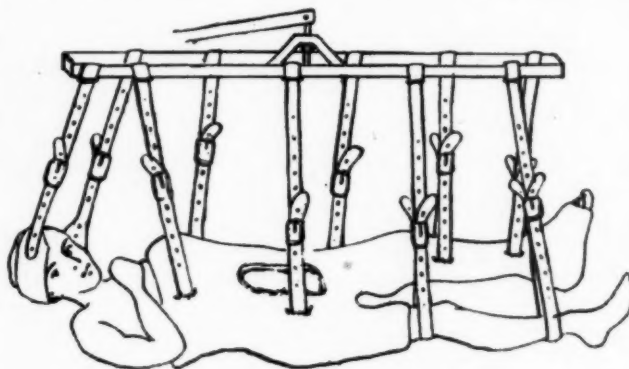


Figure 2.

approximate space of the ordinary hospital stretcher, its height is such that it can be admitted to the hospital elevator or pass through an ordinary doorway, and the employment of front wheels, which because of their diameter pass under the bed, allows the apparatus to approach the bedside with the occupation of but moderate space. Moving the foot of the bed to one side will usually be all that is necessary.

An inspection of figure 1 will amply illustrate the mechanics of the apparatus. Raising and lowering of the stretcher frame is accomplished by means of the worm-drive, thus insuring safety from slipping (rachets etc.) and eliminating any possibility of sudden jerking motions. The parallelogram (F), which changes position as the stretcher frame is raised or lowered, maintains the post (G) in an absolutely vertical position at all times, thus preventing the standard from which the stretcher frame is suspended from tilting away from the horizontal. The mechanism for raising and lowering the stretcher is manipulated by the crank (H).

Two types of leather straps are employed for suspending the patient, one a three-piece stretcher pad (A.B. and C.) and the other ordinary smooth, strong leather straps (D. and E.). In the development of these devices the following important factors were considered. In the first place it is obviously impossible to remove a complete stretcher (sheet or canvas) from beneath a patient without first lifting him or turning him from side to side. Where such manipulation can be carried out it is generally unnecessary to employ such a device as the automatic lifter. In patients, however, in whom such manipulation is undesirable and the straps may not be necessary, the divided leather stretcher pad (A, B and C) answers the purpose admirably. The legs of the patient may be gently raised and a segment of the stretcher pad placed beneath them and likewise the shoulders and head may be raised while another segment is put in place preferably beneath the pillows. With slight assistance the pa-

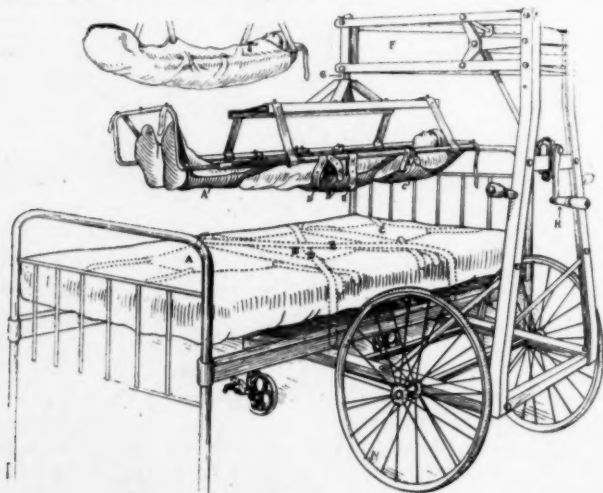


Figure 1.



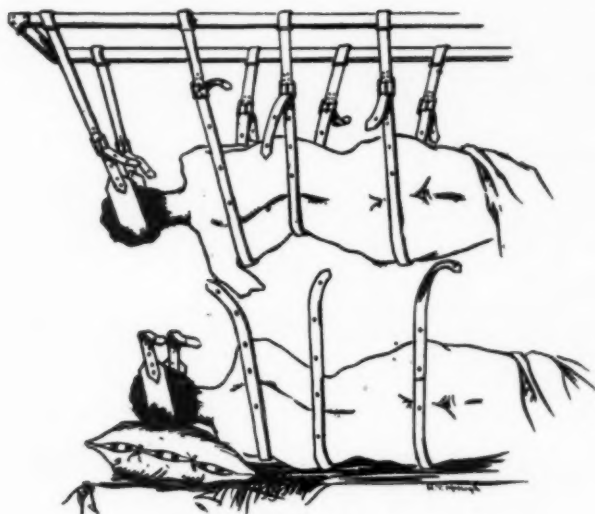


Figure 3.

tient may then raise the hips while the third piece (B) is placed beneath the pelvis.

The lifter may now be advanced to the bedside, the stretcher frame (which is adjustable as to length), lowered until it rests upon the surface of the bed, after which the straps connected with the various segments are quickly slipped over the hooks that correspond with their position (as shown in figure 1). By means of the worm-drive the patient is now lifted from the bed and the stretcher frame rotated into a position parallel with the wheels of the apparatus where, by continuing the elevation, it may be securely locked. A blanket is then placed beneath the patient and fastened above him (see insert figure 1). Before depositing the patient upon the operating table the blanket is removed and after he is in position the segment of the stretcher pad beneath the proposed field of operation is also removed to prevent soiling during operation. When necessary two supplementary straps may be crisscrossed above the center pad for the purpose of elevating this portion of the patient from the operating table while removing the stretcher pad (see fig. 1, B, D, E, B', D', and E').

For the extremely ill, (for instance in fractures, sepsis and in patients who cannot assume the prone position), the use of straps or a combination of straps and stretcher segments is indicated. In using the straps advantage is taken of the fact that beneath an individual who is lying upon a bed there are areas in which the body contacts but slightly. The regions of the neck, the loin, the level of the gluteal folds, the knees and the ankles furnish spaces through which stiff leather straps may be inserted, provided all wrinkles are eliminated from the draw-sheet. In case there is difficulty in passing these straps a metal rod may be used as a guide.

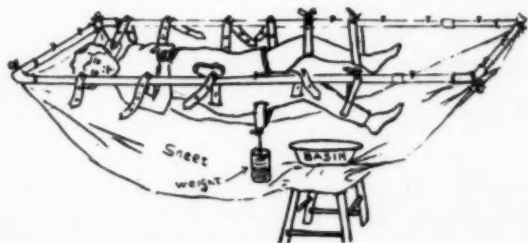


Figure 4.

After passing a strap beneath the neck or loin one may, by gently drawing it diagonally to and fro, slip it beneath the shoulders or buttocks. In this manner any desired number of straps may be slipped beneath the patient. In the class of cases in which the use of straps is imperative it is usually necessary to maintain the component parts of the body in the same relative positions occupied by them before making the transfer. This becomes a simple procedure and must necessarily follow the attachment of all straps to the frame with an equal amount of tension. For example, if a patient lies in bed with one knee flexed to a right angle the strap supporting this knee would occupy a straight line from one side of the stretcher-frame to the other, whereas the strap supporting the unflexed knee would occupy a curved position in the approximate plane of the straps which support the body. When all straps are in position and hooked the frame may be raised and the patient will be elevated without change in the relation of the parts (figure 5).

### Some Uses of Apparatus

The following are some of the purposes for which we have used this apparatus and we find that by its use the indications may be met with greater satisfaction than by any method with which we are familiar. A few illustrations will be offered merely as leads to show the great adaptability of the lifter.

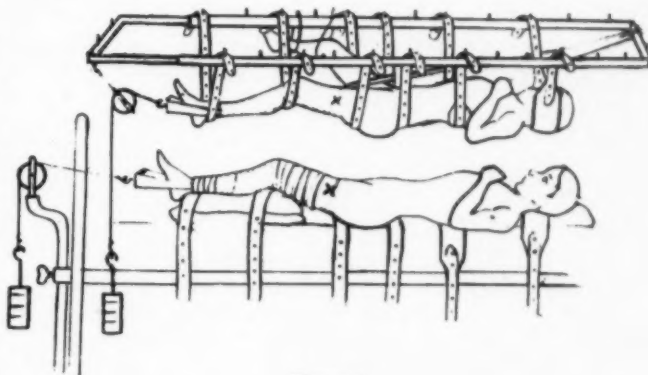


Figure 5.

Desperately sick patients must often be raised from the bed to allow bathing, change of dressings, use of the bedpan and change of bedding. One may, by the appropriate use of straps and pads, which may be allowed to remain *in situ* for protracted periods, raise and lower the patient at will. Thus all wounds, bedsores or burned surfaces upon the posterior aspect of the body may be cared for without annoyance as any nurse or attendant can, unaided, suspend the patient in a few minutes time. This attribute of the lifter is so obvious that its further amplification is unnecessary in this article. The simple fact that a nurse, during her first week in training, may, with this apparatus, raise a patient of any weight from the bed for any purpose whatever, speaks for itself.

One of the most satisfactory uses of the lifter is found in the application of plaster casts. A glance at the accompanying figures will show how it is used for this purpose. Figure 2 shows the application of a body cast including one limb and a cuff around the opposite thigh.

Figure 3 shows a simple method of applying the Abbott cast, A before and B after correction, gravity being used to correct the deformity.

Figure 4 illustrates its use in the correction of a deformity of the femur in a girl whom the writer was called to see at the end of the fifth week of treatment

of a fracture. Under local anesthesia the Grattan osteoclast (see insert, figure 4) was used to correct the deformity. After removal of the osteoclast it was found that the deformity had a slight tendency to recur and accordingly a weight of nine pounds was suspended from the limb, thus overcoming the deformity. The limb was then fixed in plaster as shown in the illustration. In this case the whole procedure was carried out while the girl was suspended upon the stretcher frame and she ate her dinner while thus suspended. It is our practice when using plaster to attach a sheet beneath the stretcher frame which may, if desired, be detached from the lifter and supported at either end by a table. Beneath the sheet a stool is placed and upon the stool and above the sheet the plaster pail or basin is set. In this manner all soiling by the plaster of Paris is eliminated (figures 4 and 7).

Figures 5 and 6 show still another method of employing the apparatus. The patient, a doctor's son 5 years of age, had sustained a fracture of the femur. He had been treated by means of Buck's extension. Position was excellent but union was not firm. It was thought advisable to apply plaster fixation, continue the extension and allow the child to be taken home.

The method of procedure was as follows: The child was lifted upon the straps and coincidentally the weight was transferred to a pulley attached to the frame (Figure 5). Counter extension was applied by means of a gauze strip placed beneath the perineum and anchored to the top of in frame. Plaster was then applied, as shown in figure 6, and extension maintained by incorporating a "U" shaped piece of metal in the cast and attaching a pair of baby scales to the same. (See insert, figure 6). Figures 7 and 8 are photographs (retouched) of the boy taken during the application of the cast and the removal of the straps.

After the application of plaster casts by this method the straps may be withdrawn or allowed to remain in place for the purpose of lifting the patient later. If they are allowed to remain in place they should be drawn gently to and fro so as to avoid pressure from their contact with the skin.

During recent years, since the Thomas splint has come into more common use, we have utilized the strap method as an aid in applying this splint. As the ring is passed upward along the limb each succeeding strap encountered is temporarily released after supporting the region just below the ring by a supplementary strap.

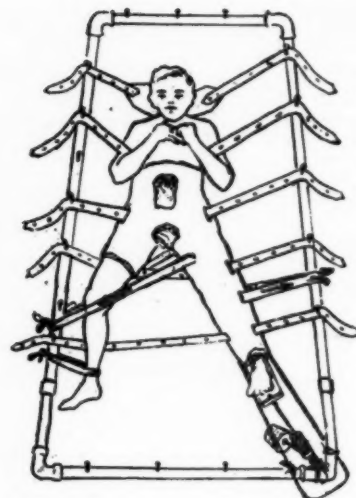


Figure 6.

This apparatus has become an almost indispensable aid in carrying out our regime for the treatment of thyrotoxicosis. This plan necessitates the transportation of the patient to the operating room a number of times for a "fake" treatment, while preparing him for operation. Each morning, therefore, the same routine is carried out as would be followed if actual operation were contemplated. In making the transfer to and from the operating table by means of this device the patient is insured against any expenditure of energy, the amount of nervous excitation being reduced to a minimum.

Aside from the uses enumerated above, there are numerous indications for an apparatus of this kind in systematically caring for the sick and injured. The awakened interest in the psychic care of patients which has become manifest during the last few years is bringing to the medical and nursing profession a realization that physical suffering must be reduced to the lowest possible point. Furthermore, the appreciation of the fact that it is important to prevent trauma to those who are unconscious seems to be gaining a foothold. It is therefore our hope that by the consistent use of some device like the one here described we may more nearly reach the ideals demanded by those who are in need of such assistance.

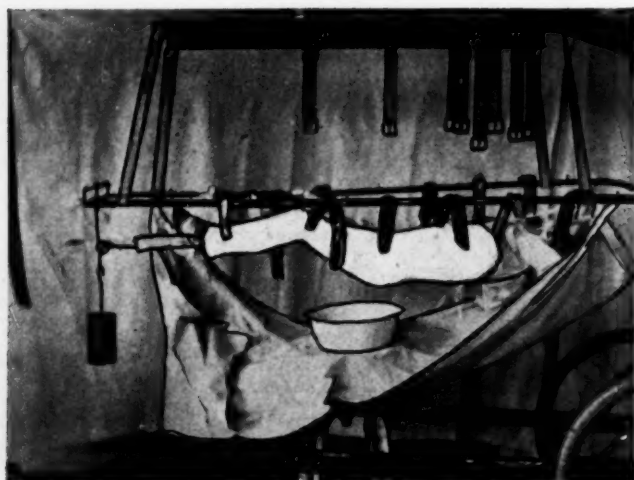


Figure 7.

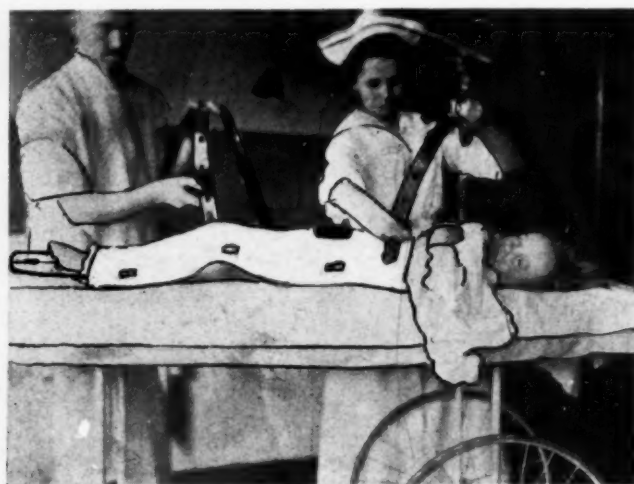


Figure 8.



## THE SERVICE DEPARTMENT'S ROLE IN THE CARE OF HOSPITAL FURNITURE\*

By JOHN A. WYLLEY, FOREMAN, GENERAL SERVICE, UNIVERSITY OF CALIFORNIA HOSPITAL, SAN FRANCISCO, CAL.

**C**LEANING, polishing, handling and storing of furniture constitutes a large part of the duties of the service employee. Careless handling and storage of furniture results in considerable loss in damaged walls, floors and equipment.

On linoleum floors furniture should never be rolled around on its castors, nor should it be placed on the floor without first supplying blocks on which to place the castors or gliders. Dents, holes and cuts appear from failure to take this precaution. Unsightly spots thus result.

Articles that are to be moved for any considerable distance should always be carried, and although they may be supplied with castors, should never be rolled. Every article of any size should be carried separately, not piled one on the other, in order to save a trip, as furniture is built to take a certain weight, and is not intended to act as a vehicle for the transportation of other articles.

Furniture should always be stored where there is an abundance of light, air and where there is even temperature. The room should be dry and of sufficient size to permit proper piling and arrangement. All heavy articles are stored nearest the entrance, and if to be stored for any considerable time, should be covered or wrapped with paper. Heavy furniture, particularly desks and articles made of wood, are subject to veneer warping, due to dampness, excessive heat or heavy weights placed on top of them for any length of time.

### Preparing Furniture for Storage

Mattresses in good condition should be piled close to the light and in piles of not more than six, otherwise the bottom mattress will be flattened, thereby necessitating recurling. Rugs are to be rolled, not folded, and if possible suspended from the ceiling in the same manner as a window shade. Rugs should be taken out of doors at least twice a year and given an airing and inspected for moth eggs.

All equipment which has exposed metal parts that have not been finished with paint, should be given a heavy coating of vaseline to prevent the possible formation of rust.

Beds are piled with suitable padding between each and in such manner that the head and foot piece will always be with the spring for which they are intended. Bolts and nuts belonging to beds, cribs, or bed frames, should always be placed in an envelope or paper and tied to the bed to which they belong.

Rubber materials belong in a cool dry place in the storeroom. Rubber rots quickly if exposed to heat and, if damp, will mold. Rubber sheeting should always be rolled upon a broom handle or round stick before storing.

As white wood furniture is effected by the lack of light and by dampness, it should be stored where it will have the maximum amount of light available. Mirrors are destroyed by dampness and disinfecting solution so that when stored they should always be protected by suitable paper wrappings.

All acids and cleaning solutions or preparations belong on the shelves, properly labeled, and in the darkest part of the storeroom. Acids are effected by light, which generally changes their color, and may impair their effectiveness.

### Preserving Metallic Surfaces

Rust, scale and corrosion are the principal reasons for the deterioration of metal and metal plating although, as stated before, continuous cleaning with harsh sands and powders, or the application of acids, will also wear the surface down to the replacement point.

Exterior metal work is usually made of iron, such as roof vents for plumbing systems, ventilators, fire-escapes, wire stays for poles, sheet metal trap doors, water-ways and drainage pipes. Frequent painting is required to prevent the formation of rust; generally this work is done every year during the summer months. If rust has already taken hold, then it becomes necessary to remove all old paint, scrape off the rust and treat the surface first with a coat of red lead followed by one or two coats of good cement paint.

In most states laws covering the fire regulations of buildings, require that the fire escape be kept in good condition by frequent painting.

Red lead and spar varnish are the best coverings to use on all types of exposed metal surfaces to prevent rust or corrosive action due to atmospheric conditions. Spar varnish may be used on the soft metals such as brass and copper, brass, nickle, etc., where galvanized link foot mats are used. Spar varnish will keep the links from rusting and prevent rust from being carried into the building on the shoe. Zinc and monel metal can be cleaned effectively with a detergent, or cleansing powder, the less powder used the better results obtained. Zinc will take a fairly good polish if rubbed hard; monel metal does not rust and will take a good polish with ordinary metal polish. Old brass, oxidized copper and such special finishes should not be polished, if they become dirty or flyspecked. These marks can be removed with a cloth that has been dipped in denatured alcohol. A coat of good lacquer or waterproof varnish can then be given.

Some of the metal fittings used about the hospital require an occasional drop of oil, particularly the door hinges and wheel axles of gurneys, trucks etc. Mineral oil should be used for this purpose, as it will not gum. Vegetable oils such as the popular bottled products, castor oil, salad oil etc., should never be used in contact with metal surfaces, as they gum and stick, collect dust and do not properly lubricate the surface. Hinges that have become gummed through the use of improper oils, should first be cleaned with lubricating oil, not with kerosene, and then replaced and oiled as above.

### Aluminum Paint for Radiators

Radiators are generally painted with aluminum paint, a special preparation containing no turpentine or linseed oil, which is used because it does not discolor readily when subjected to heat. As for all metal objects the first coat

\*This is the fourth of a series of articles on the general service department of the hospital, prepared for THE MODERN HOSPITAL, by Mr. Wylley.

is red lead followed by one or two applications of aluminum paint or gild.

Any surface upon which the enamel has been baked, such as bedside stands, beds, etc., can be readily cleaned with either furniture oil or detergent powder. In either case the surface should be left dry so that it will not take a finger print.

Any surface upon which it is desired to use a glass top, whether enameled or wood finished, should have proper protection to prevent scratching or chipping. This may be accomplished by cutting rubber tubing to the desired thickness and placing it beneath the glass.

### Knowledge of Painting Desirable

Painting is one of the essential things for the service man to know. He should have some knowledge of the preparation of the surface, the mixing of common paints and their application. All surfaces to be painted must first be cleaned of surface dirt and grease. If the surface to be painted is plaster it should then be given one coat of the color in which it is intended to finish, which should be followed by a coat of sizing and then the first undercoat, then the finishing coat.

The object of sizing the wall is to prevent suction from the pores in the surface. Many painters size the wall first and apply the first coat of paint over this. The other way is better, especially in the hospital, because when an object is brought into contact with the surface breaking through the paint and removing the sizing, a white spot will show; whereas if the first application is a coat of color, this will remain on the wall after the sizing above it has been knocked off.

On a wooden surface the preparation is the same with the exception that the wall must be smoothed down with sandpaper, nail holes filled with putty, and then sized. Where enamels are to be used to finish, such as around door frames, moulding and trim, after the first coat is dry the surface must be gone over with double "O" sandpaper and brushed off before applying the second coat. After the second coat is dry, it must be rubbed down with powdered pumice and oil so that it will be perfectly clean, free from dust or brush marks, wiped dry and the third coat applied. Three coats will make a good job, though in many cases as many as five are used, all are rubbed down before applying the next coat.

Paint cannot be hurried and must be given a reasonable time in which to dry and set properly. This usually takes thirty-six hours, but forty-eight should be allowed, if possible, in order that none will be rubbed off in the finishing.

### Flat Paint and Finishing Coats

The first two coats applied are always flat, that is, not of the enamel type. Flat paints contain a minimum of oil and a large amount of turpentine, while the finishing coats or enamels contain a larger portion of oil and a small amount of turpentine. To make a gallon of flat paint, a quart of oil is used to balance the turpentine and white lead. It is better to buy the finishing coats, as these must be made in accordance with exact formulas. Before using the paint it should be strained at least twice through several thicknesses of cheese cloth, and thoroughly mixed.

Light paints cannot be used economically upon a dark painted surface. The old surface should first be removed with strong soda or lye solution, and the surface again built up as a new one. Tint is a water preparation and

can be removed by washing off with cold water and sponge.

Before tinting the surface must also be sized just as in the case of paint; sometimes shellac is used for this purpose, but is more expensive than the regular glue or starch sizings. Sizing is frequently used under wall paper for if this is done the paper takes better hold and is not so apt to crack or peel. If the wall is very rough or sanded, it should first be covered with light cheese cloth, then sized and finally the paper applied. Plaster of Paris is used to fill cracks in plaster before painting. Putty is used for the same purpose on wooden surfaces. Both must be sized before applying the paint.

### Cementing and Cement Surfaces

It is frequently necessary to make small repairs in cement work or to make platforms, etc., from cement. Cement mixing and installation is easy, if the general rules are carefully followed.

Smooth cement is made from a mixture of 100 pounds Portland cement to four cubic feet of clean hard sand with a sufficient quantity of water added to make the mass pile easily. The mixture should not be wet enough to run. When it is mixed the operation should be done quickly and thoroughly, as a great deal depends upon this mixing. Every tiny particle of cement must be brought into contact with the water, and once this is accomplished, the mass begins to set.

As soon as the mixing is completed, the mass should be put into place, and carefully tamped down so that no air voids are left to cave in when the job has been completed. The strike board is used to level off, and the trowel to finish, if a smooth surface is desired.

### How Concrete Is Made

Concrete is made up in the same manner, except that, instead of using sand, some other substance is substituted such as small pebbles, marble chips, crushed rock etc., The finished job must not be permitted to dry too quickly. In order to prevent this, it may be covered with wet sacks for a week or ten days after which time they may be removed and the cement permitted to dry. Cement surfaces that are dried out too quickly are likely to dust, that is, the surface breaks up and becomes uneven and difficult to clean. A floor that has become dusty may be treated with linseed oil and turpentine in equal amounts.

Waterproof cements are made by adding special preparations to the cement when it is mixed. These are patented preparations which may be obtained ready to use. Brick dust may be added to give a red color, and lime to give a white color.

Cement moulds and blocks are made of the same constituents except they are made soft enough to pour into the frames, and must be given a proportionate time in which to dry. Cement for wood is made of fish glue which may be obtained from any hardware store. It comes in sheets like glucose, and is melted by adding a small quantity of water. This is the type of cement used for the repair and manufacture of furniture and can be used to repair chairs, tables, desks, etc. Cement to hold contacts is made up of four parts beeswax, twenty parts resin, and one part plaster of Paris, melted together and poured where desired while hot. Marble is held together by a different type of cement, this is made by mixing twelve parts Portland cement, eight parts sand, one part infusorial earth and a small quantity of silicate of soda. A paste is thus made which should set within twenty-four hours.



## DECORATIVE INLAID FLOORS—A NEW FEATURE IN CHILDREN'S WARDS

BY JAMES H. STEDMAN, PRESIDENT, STEDMAN PRODUCTS COMPANY, SOUTH BRAINTREE, MASS.

"Old Noah he did build an ark,  
He built it out of hickory bark.  
He drove the animals two by two,  
The elephant and the kangaroo,  
And then he nailed the hatches down  
And told outsiders they must drown."

THUS did our old friend Noah engage in his first and, as far as we know, only maritime adventure, brief, but quite essential it seemed at that time. It was fortunate that he got all the animals in, for what would life be worth without our Towser dogs and Tabby cats. The child who has not known the joy of animal pets has missed a lot of life much worth while. In a home I know of where there is but one child there has been a continuous procession of animal pets; always one dog, sometimes a whole family of puppies, cats and kittens come and go, and there have been rabbits, chickens, a lamb and twin calves. Just now the animal family consists of a pony, cow, goat, one bantam hen, several gold fish and a rapidly growing Johnny Tadpole, beside the black and white cocker spaniel and the perfectly black mother cat, whose last kittens have just found new homes. The juvenile mistress of this aggregation has been accustomed to such animal friendships since her earliest years, and is consequently unafraid of them or of other animals.

And so the thought of bringing to sick and crippled kiddies memories of their pets at home, or suggestions of friendly creatures that they did not know, came to the members of the building committee of the Children's Hospital, Columbus, Ohio. The thought has found expression in the animal and bird designs in the floors of all three of the solariums in this new hospital. The material used is reinforced rubber of one-quarter inch thickness in tiles ten inches square. The inlays are done in black and are inlaid in sheets of white with a touch of black running through them.

The second floor shows the conventional story-book animal pictures we are all familiar with, while the third floor has been given over largely to bird designs, as shown in the accompanying illustration. It will readily be seen that the decorative features of the floor fit nicely with the furniture and mural decorations, and make of the floor something other than

just a thing. It gives the necessary touch to the room, and harmonizes with the other attractive features.

On the fourth floor are shown the odd conception of birds and animals that are seen in the Hopi Indian pictures from the Southwest. One of the illustrations herewith shows this in a close-up form, while the other shows the conventional animals in the same way.

The Columbus plan made such an impression on Dr. W. L. Babcock, Grace Hospital, Detroit, Mich., that he decided to use animal inlays in a children's ward. As this ward is rather narrow, the use of the animal inlays was confined to the aisle running the length of the room, the beds being on either side. In this installation the effort was made to show the animals with as much action as possible, for example, a dog balancing a ball on his nose,

another dog holding a paper hoop as a smaller dog is seen jumping through, a parade of elephants, trunk to tail, a monkey, goat, calf, rabbit, parrot, etc., each in a characteristic attitude. In this ward the material used is reinforced rubber in large sheets, sixteen feet long, forty inches wide, and one quarter of an inch thick. On each of these sheets of material are a number of inlays, the main part of the sheet being in gray paisley-like mottling, while the animals are in plain red.

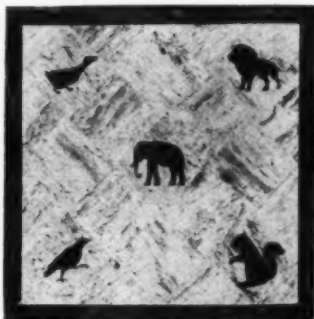
In all of this endeavor at both hospitals, the idea has been to give the children something to think of that would help shorten the hours of suffering through the introduction of permanent pictures depictive of happy childhood hours under different surroundings. Such an atmosphere is also helpful to the anxious parent, as it helps to lessen the general hospital formality.

The opportunity for diversification of color and design scheme is almost without limit. The material is practically indestructible and from a non-slip standard, is essentially a safe floor. This latter fact is borne out by the experience of the New England Peabody Home for Crippled children, West Roxbury, Mass., where both boys' and girls' wards are covered and where it is no uncommon sight to see crippled children scurrying across the floor at apparently break-neck speed, and without the slightest fear of falling.

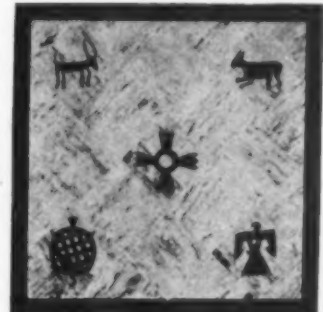
In the kindergarten the inlays are also made useful in nature study instruction.



Second floor solarium, Children's Hospital, Columbus, Ohio.



Story-book picture inlays.



Hopi Indian picture inlays.

## DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York  
and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 370 Seventh Avenue, New York

### PRINCIPLES AND FORMS FOR OUT-PATIENT RECORDS\*

IN considering the items found on admission cards to institutions, there were available for study twenty-six cards which could be compared as to content. All items were listed and those appearing any considerable number of times were as follows:

Item on admission card	Number of cards containing item
Name of institution.....	26
Clinic hours .....	25
History number of patient.....	22
Admonition always to bring card.....	22
Clinic days .....	21
Name of patient .....	20
Address of institution .....	17
Department to which patient is to go .....	17
Date card is issued .....	12
Name of one or more doctors.....	12
Address of patient....	7
Admonition to keep card clean .....	7
Statement that if card is lost, charge made for a new one (4 of these specify charge)	6
Age of patient .....	5
Copy of "penalty for false representation"	17
The purposes of the admission card are to introduce the patient to a definite clinic or clinics in a certain out-patient department and to identify him and locate his history at subsequent visits.	
The name of the institution printed on the card is sufficient to identify the card as coming from that particular institution. The	

address of the institution is generally well enough known so that it may be omitted from the form. It is difficult to identify the bearer of the card as the one to whom it actually belongs. Name and address do not accomplish this since, if a person wishes to use the card of another, he can give as his own, the name and address on the card. Age is a help, this would partially exclude the use of admission cards by those to whom they were not issued.

#### History Number Identifies Patient

The item necessary to identify this history as referring to a particular patient is the history number. An added item might be the name of the patient entered as a precaution against error, since it is possible to make a mistake in copying the number, and a check-up can then be made by referring to the index file. The advantage in this instance in having the name on the card rather

than asking it of the patient is that the spelling or even the name itself may be different from that given at the time of the first visit. The name on the card may also be an advantage to the patient in identifying it as his own if several members of a family are attending the same institution.

The name of the clinic on the card is an aid in routing the patient, especially since names of some clinics are difficult for patients to remember. This is accomplished by various methods on the admission cards studied; a large number of institutions use a different color for each clinic, printing the name of the clinic

### Studies of Existing Forms

IN the August number of THE MODERN HOSPITAL the committee on records published the first part of its conclusions as to the minimum record forms required for the adequate functioning of an out-patient department. Included in the previous installment were facsimiles of the forms as drawn up by the committee and general recommendations concerning the use of these forms.

The present installment presents the studies made of existing forms and the reasons given by the committee for its decisions as to minimum requirements.

on the card. This seems to be a workable method for an out-patient department having not too great a number of clinics, but requires issuing several cards to a patient attending several clinics—hence is an additional expense. Other institutions use cards of one color only but print the word "clinic," leaving space in which to write or stamp the name required. Still others print the word "clinic" several times with blanks after each. One card studied prints a list of its various clinics with

\*Part II: Report of Committee on Records of the section of administration, Associated Out-Patient Clinics, New York, N. Y. Dr. George O'Hanlon, chairman of the section on administration, appointed a special committee on records consisting of Dr. E. M. Bluestone, Mount Sinai Hospital, chairman; Dr. Charles B. Bacon, City Hospital; Dr. Mark L. Fleming, Bellevue Hospital; Mr. Joseph D. Flick, the New York Society for the Relief of Ruptured and Crippled; Dr. Frederick MacCurdy, Presbyterian Hospital; Mr. James U. Norris, Woman's Hospital, and Mr. George F. Sauer, Lenox Hill. Prior to the preparation of the report, Dr. Bacon and Mr. Sauer resigned. The material was gathered for the committee and the report prepared by Elizabeth L. Breeze of the Associated Out-Patient Clinics. The committee would be glad to receive from readers any criticisms, which may be addressed to Dr. Alec N. Thomson of the Associated Out-Patient Clinics, 17 West 43rd Street, New York City, who acted as secretary to the committee.



space after each for checking. These latter methods are advantageous in that they allow the use of one card only for a patient attending several clinics.

Most admission cards provide items of information of use to the patient, such as address of the institution and clinic days and hours. The item of address is unchanging and presents no difficulties. When different colored cards are used for each clinic, the admission time is usually printed. When only one card is used but the hours are the same for all clinics the time can easily be printed on the card. In several cases studied, where only one card is used, but the time is not the same for all clinics, the various names of the clinics are printed with the hours for each. A convenient method of indicating on a patient's card the clinic or clinics to which he is assigned, together with the time of each, where this is not the same for all clinics, is to use a series of rubber stamps with the name of a clinic and its admission time on each.

It seems to be a general rule to print on the card some admonition as to its care, and especially to bring it always when coming to the out-patient department. Such statements in print may be of value. Six of the cards examined make the statement that if the card is lost a charge will be made for a new one.

#### Minimum Admission Card Items

The following items were determined by the committee to be essential for all out-patient admission cards:

Name of patient, history number, clinic, date of patient's first visit to the clinic, clinic time (days and hours), name of out-patient department, admonition to bring the card.

One of the compulsory requirements of the State Board of Charities of the State of New York is that the "penalty for false representation" should be printed on the reverse of the patient's card. Since in a good many instances patients can not understand legal phraseology, the committee felt that the substitution of a simple interpretation of the law would be of more value. The following wording was thus suggested:

"This out-patient department is for the treatment of the poor. The law does not permit us to treat those able to pay for the services of a private physician."  
(Section 296, Chapter 55, Consolidated Laws.)

It was further suggested that this statement be printed on the face of the admission card since it would permit of running the card only once through the printing press, thus decreasing the cost.

#### Index Cards

The index cards of eighteen institutions were examined. The following list gives those items occurring most often:

Item on index card	Number of cards containing item
Name of patient.....	17
Address of patient.....	16
History number .....	15
Age .....	13
Date of admission.....	10
Name of institution.....	8
Name of relation.....	7
Occupation .....	6
Diagnosis .....	6
Marital condition .....	6
Department .....	6
Color .....	5

Remarks .....	4
Sex .....	4
Nativity or birthplace.....	4
Nationality or race.....	4

The chief administrative purpose of these cards is to furnish an alphabetical index to the numerical history file. It is used in the case of old patients coming without admission cards and patients who claim to be new; in the latter case a check-up is made by means of the index cards to insure no duplication of history sheets.

Index cards should show all the clinics which the patient attends; first, for identification purposes; second, for the sake of locating the history under a decentralized filing system in cases where the history is transferred from one clinic to another when the patient is transferred; and third, in out-patient departments which maintain no special diagnostic file, to indicate to the clinical research worker the identity of clinical records.

There are thirty-two other items appearing besides those listed above. The number of items on the individual cards varies greatly—from two (name and history number) to fourteen. The average is about nine but this is probably more than is necessary for identification purposes only. Some of the cards record information other than for this purpose, such as in other institutions would go on the history sheet or possibly on a social service card.

The index cards are filed alphabetically by surname; therefore it is most important that names should be spelled accurately. In order to facilitate this it is suggested that wherever possible the patient be required to write his name for the guidance of the clerk. Cross-indexing is advantageous in the case of names sounding alike but spelled differently. In this connection consideration should be given to one of the phonetic systems in vogue such as the Russell, promoted by the library bureau.

It is preferable that these index cards be typed; or if this is not feasible, the names should be printed. In order to minimize clerical work the card should contain as few items as possible, yet there must be enough information to identify the patient. Name and history number are not sufficient because of the numerous instances of duplication of names among patients and also because foreigners so often simplify the spelling of their names or change them altogether after residing in this country for some time.

The following items were considered to be essential for all index cards: (1) Name of patient; (2) history number; (3) address; (4) sex; (5) date of admission; (6) clinic, and (7) name of out-patient department.

It was also the opinion of the committee that, while not essential, it might be advisable to include age, color and remarks. Considering other features that are found on the cards it was felt that as the prime function of an index card is to identify the patient and insure the location of his record, there should be a minimum amount of writing on the card, so that admission might be hastened. Probably the amount of information listed above will be found sufficient to identify the great majority of patients. If occasionally there are found several cards containing information so similar that identification of the patient is not certain, it will prove easier to examine the histories of these few individuals than to add several more items to the index card for every patient.

A statement of the patient's inability to pay for the services of a physician is required by the State Board of Charities. In order to limit as much as possible the

number of forms used in an out-patient department, this statement can be printed on the index card. The following wording is suggested:

"This patient claims inability to pay for the services of a private physician."

### Transfer and Refer Form

Twenty-nine transfer forms were studied, including transfers between out-patient department and hospital, and between the various clinics of the out-patient department. These forms combine the transfer and refer slip with the abstract form, though two separate forms are desirable. The following tabulation gives those items appearing most often:

Item on index card	Number of cards containing item
Name of institution.....	27
Name of patient.....	27
Name of physician.....	26
Date of transfer.....	22
Diagnosis .....	20
History number .....	18
Department or service from which transferred.....	17
Department or service to which transferred.....	17
Recommendations or remarks.....	16

Terms were defined as follows: *Transfer* indicates that the physician recommends the patient to some other clinic in the same out-patient department or to some other institution, no further attendance being desired in the parent clinic. *Refer* indicates the need of treatment or consultation in some other clinic, in the same out-patient department or in some other institution, continued attendance being desired in the parent clinic.

Under both centralized and decentralized filing systems the transfer and refer slip is for administrative purposes only—to guide the patient to the clinic indicated.

Under the centralized and unified system the history follows the patient automatically to the hospital or the clinic indicated. If the record system is decentralized and non-unified, this necessitates the sending of a clinical abstract unless the history is transferred either temporarily or permanently.

A notation of the transfer or refer should be made on the history in the parent clinic and a like notation on the alphabetical index card, whether this card be kept within the clinic or in the central office. In a decentralized system this serves to inform the physician of the parent clinic where to locate the patient or send him, in case he comes back to his clinic by mistake, or where to find the patient's history in case he is transferred back again for treatment.

In out-patient departments where there are no index cards to the clinic records, a card bearing a note of the location of the history should be slipped into the files in place of the history, if the latter is removed for transfer to the hospital. In the case of the out-patient department with a decentralized filing system, this should be done if the history is sent to another clinic.

The committee recommended that the history abstract, or any other clinical information should not be carried by the patient himself, but should be transferred by messenger or mechanical conveyor. This helps to preserve the records in good condition, prevents their loss and makes reading by the patient impossible.

The following items were deemed sufficient for the transfer slip:

(1) Transfer; (2) refer; (3) date; (4) from; (5) to; (6) to report on (day and hour), (7) name of out-patient department.

This form may be printed on inexpensive paper since, as it will be shown, it is for temporary use only.

One of the words "transfer" or "refer" is to be encircled as the one designated. The name of the original clinic is to be stamped or written in; the name of the clinic to which sent must be filled in.

This slip is attached to the patient's admission card and the patient sent at once back to the registrar. As only one admission card is recommended, regardless of the number of clinics the patient is attending, the name of the clinic to which sent and the date is stamped or written on the card already in the patient's possession. If transferred, the name of the clinic from which sent is crossed off; if referred, this is not done, showing that the patient is attending both clinics. If an appointment system is used, the transfer or refer is designated by the appointment on the back of the admission card. (If separate admission cards are issued for each clinic attended, the registrar gives the patient a new card for the clinic to which sent; if transferred, the patient's old card is destroyed; if referred, the patient keeps both cards.) The registrar then destroys the slip, unless statistical record is to be kept of the number of transfers and refers, and daily attendance is not recorded in a central office from the histories.

If a central unit filing system is maintained and if the patient is sent by the registrar to the new clinic on the same day, his history is sent by carrier to that clinic. If the patient cannot go to the new clinic on that day he is told when to return. If decentralized filing is maintained, the history preferably, or an abstract, is sent by the same method. This abstract is to include the patient's name and admission card number for identification.

If the patient should leave the out-patient department without showing his transfer slip to the registrar but brings it the next time he comes, he then goes through the same process as described above. If he should lose the slip, his admission card indicates only the clinic from which transferred or referred and, unless he informs the registrar of the change, he will be routed to the original clinic. There the physician sees his notation of the previous session and gives the patient another slip. In this case the patient should not be required to pay a second fee, so that the physician does not collect the fee receipt, but allows the patient to retain it for admission into the second clinic. If, however, the patient informs the registrar of his transfer or refer, the registrar sends for the history, sees the notation thereon and acts accordingly.

It is important for the physician, in transferring or referring a patient from his clinic to some other, to indicate the date on which he wishes the patient to report. This is especially true in sending a patient from hospital to out-patient department or vice versa since in such instance the physician might have reason to set the date for some specific time in the future. This is not so apt to be the case in transferring or referring a patient from one clinic of the out-patient department to another—usually the earliest date possible is the most desirable. In any case, when the physician fills in this item, the same date should go on the abstract form where this is used, otherwise on the history sheet after the notation of place to which transferred or referred.

The point was brought out that often advice about a patient is asked of one physician by another and no record of this appears anywhere. The committee recommended that refers should be counted as visits and should be recorded as such.





**I**N the 5th Edition, Dental Materia Medica and Therapeutics, Page 284, Prinz wisely points out: "An ideal dentifrice must be free from danger as far as the mucous membrane, the teeth and the organism as a whole are concerned."

Oral hygiene is a physiologic and not a therapeutic measure and medication carried out only under professional direct supervision would seem to be the proper course.

Colgate & Company will continue their policy of complete co-operation with the dental profession and are ready, as ever, to act in accordance with such further advances as may be established through laboratory research and clinical experience.

*In case you have not yet received The Bunzell Research Bulletins Nos. 1, 2 and 3 we will be glad to mail copies on request.*

MEDICAL DEPT.  
**COLGATE & CO.**

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199 Fulton St., New York



When using advertisements see Classified Index, also refer to YEAR BOOK.

As previously stated, the centralized unit system of filing makes the clinical abstract unnecessary. Where such system is not in use it was concluded that the transfer of the history between clinics and hospital was preferable to using an abstract form. It gives the physician an opportunity to review the case in its entirety and may save repeating time-consuming examinations and expensive laboratory procedures, beside the work of abstracting. However, where this is not considered practicable or safe procedure, an abstract should be sent in advance of the patient. It should be sent automatically for every patient transferred or referred. If this is not done, it means that when the patient reports, the physician must, in order to benefit by the patient's written history, either go personally to the record room to review it or he must send for it. In either case it causes delay and physicians seldom avail themselves of either of these privileges, preferring rather to treat the patient without the aid of his previous history.

The items recommended for inclusion on the abstract form are: (1) Name of out-patient department; (2) name of patient; (3) history number; (4) refer—transfer. (5) date; (6) from; (7) to; (8) to report on (day and hour); (9) clinical abstract; (10) laboratory findings; (11) remarks; (12) signature of physician; (13) instructions for use of sheet.

The clinical details are left to the clinician. This abstract can be used as the basis of the history sheet in the new clinic.

The abstract should be made out preferably by the physician transferring the patient; otherwise by a trained worker (graduate nurse or social worker) in which case the physician should assume responsibility by initialing the completed abstract.

The history or abstract can be transferred by any available messenger within a reasonable time, depending on the urgency of the case, provided the patient is to report on the same day. Otherwise the transfer can be made at the end of the clinic session to await the arrival of the patient. In the case of transfer from clinic to hospital, the history or abstract goes to the admitting office, to be incorporated in the hospital record when the patient is admitted. When he is discharged, the out-patient department history (if with the hospital records) should be separated out in the record room and returned, a note being made on the hospital chart "See also O.P.D. number ...". If the patient does not report at the hospital or if he is refused admission, the history should be returned to the out-patient department from the hospital admitting office.

The use of an abstract such as described above was strongly recommended for use in transferring patients to other health agencies, the abstract to be mailed rather than carried by the patient. This makes it possible for the new agency to begin follow-up if the patient does not report at the time indicated.

### History Face Sheet

The history forms of fifty-five out-patient departments were examined. The following list shows those items which occurred most often:

Item	Number of forms containing item
Name of patient.....	55
Address of patient.....	54
Name of institution.....	53
Age .....	53
History number .....	50

Diagnosis .....	49
Date of admission.....	46
Department (or clinic) .....	43
Marital condition .....	42
Occupation .....	41
History .....	35
Signature of physician.....	32
Sex .....	27

There are fifty-four other items which occur less frequently, twelve appearing but once each in the histories studied. These fifty-four items practically all have to do with the patient's social and financial condition; very few are of a *general* medical nature, such as "complaint" and "symptoms."

Only sixteen of the fifty-five histories, less than 30 per cent, contain detailed outlines for history and examination, such as necessitates a different form for each department. The other 70 per cent simply print the headings for the needed social history of the patient, and either follow this by the words "history" and "examination" conveniently spaced, or leave the rest of the sheet blank, for the writing in of the medical history and examination in narrative form. This allows for a freer notation of any significant conditions which are somewhat out of the ordinary and would not be apt to appear on a printed outline. Some out-patient departments specify definite items which the examining physicians in the various clinics must cover in their written histories and examinations of the patients and supply these to the physicians as printed or typed outlines. These are kept in a convenient place for reference, but are not incorporated as such in the history forms.

The following items were recommended as minimum administrative items: (1) Name of out-patient department; (2) name of patient; (3) history number; (4) address, (please note change of address); (5) date of admission; (6) clinic, (note change in clinic); (7) sex, (encircle item designated); (8) civil status; (9) age; (10) exact occupation.

These items should go above a heavy printed line near the top of the history face sheet. Clinical headings, including "diagnosis," were left for later decision after consultation with clinical groups.

The recommendation was made that the chief of clinic review each history; this would enable him to keep in touch with his physicians and the records of the patients.

The continuation sheet of the history requires only the patient's name and number and the page number. When more than one history sheet is required for a patient, sheets should be gummed together.

### PLANS FOR DIETETIC CONVENTION MATERIALIZING

(Continued from page 259)

ings. The rates are American plan, as follows:

Single room per day		
Without bath .....	\$8.00	\$ 9.00
With bath .....	9.00	10.00
Double room per day		
With bath and 2 beds.....	\$8.00	per person
With bath and 3 beds.....	7.00	per person
With bath and 4 beds.....	6.50	per person
Double room per day		
Without bath and 2 beds.....	\$7.00	per person
Without bath and 3 beds.....	6.50	per person
Suites with single beds		
2 double rooms—bath between for 3.....	\$9.00	
2 double rooms—bath between for 4.....	7.50	
2 double rooms—bath between for 5.....	7.00	
2 double rooms—bath between for 6.....	6.50	

A reduction of one and one-half railroad fare on the certificate will be given to all members attending the meeting.



# Overcoming Mal-nutrition in Infants and Children

Zsigmondy determined that pure gelatine is the most powerful of the protective colloids. (*Zsigmondy, Z. Anal. Chem., 40; 1901*)

In the recent research of the specific uses of pure gelatine in the dietary, conducted by T. B. Downey, Ph.D.—Fellow at the Mellon Institute, University of Pittsburgh, it was conclusively proved by standard feeding tests that 1% of pure plain gelatine dissolved and added to cow's milk, will increase by 23% the nourishment obtainable from that milk.

This dietary discovery gives gelatine inestimable value in infant feeding because it promotes the complete absorption of the milk nutriment with the minimum of digestive effort and goes a long way toward the prevention of colic, regurgitation, and bowel disorders in the bottle-fed baby.

The prescribed formula for modification of milk with gelatine is as follows:

Soak for ten minutes one level tablespoonful of Knox Sparkling Gelatine in  $\frac{1}{2}$  cup of cold milk taken from the baby's formula; cover while soaking; then place the cup in boiling water, stirring until gelatine is fully dissolved; add this dissolved gelatine to the quart of cold milk or regular formula.

## FREE—To Physicians and Hospitals

We shall be glad to send free, upon request, scientific reports on the health value of gelatine with additional copies of the above formula for milk modification, together with valuable recipes for gelatine dishes useful in the dietary.

In addition to the family size packages of "Plain Sparkling" and "Sparkling Acidulated" (which latter contains a special envelope of lemon flavoring,) Knox Sparkling Gelatine is put up in 1 and 5 pound cartons for special hospital use. A trial package at 80c the pound will be sent on request.

# KNOX

## SPARKLING GELATINE

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Charles B. Knox Gelatine Laboratories  
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Free from harmful acidity, artificial coloring, and synthetic flavoring.



## OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by LOUIS J. HAAS, Director of Men's Therapeutic Occupations, Bloomingdale Hospital, White Plains, N. Y., and  
MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.

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## OUTLINE OF DISTRICT AND CURATIVE WORK SHOP DEPARTMENT

SINCE January, 1921, there has been in connection with the Boston School of Occupational Therapy and its training course for occupational therapists a department of district and curative work shop. This department has proved invaluable in putting the students into the atmosphere of scientifically applied occupational therapy during their training, as well as enabling us to care for many patients greatly in need of such treatment under the ideal conditions of close contact with an enthusiastic student group.

The department has two divisions: the district work, giving treatment in the homes of patients, and the curative work shop in the school building where the patients go daily for treatment.

The curative work shop has been treating patients from thirty different organizations, hospital out-patient departments; insurance companies; district nursing association, private doctors, etc.

Only patients are enrolled whose recovery will be contributed to, or hastened by occupational therapy; or, in the case of chronic invalids, those who can be helped to a more normal condition.

Looms, tools, and other items of equipment, are constructed or changed for the individual needs of the patients; rest periods are frequent, and nourishment is given curative shop patients every morning.

Daily records are kept for each patient, and measurements taken weekly for the range of motion of injured joints and muscles. Doctors are in constant consultation, and close connection is always kept between the hospital or organization sending the patient and the department.

Jan. 1, 1921 Jan. 1, 1922

### DISTRICT AND CURATIVE WORK SHOP DEPARTMENT Report of First Year

#### Two Trained Aides

Number patients enrolled Jan. 1, 1921.....	3
Number patients added in 12 months.....	111
Number patients discharged.....	72
Number patients enrolled Jan. 1, 1922.....	42
Number calls made.....	1,559
Business appointments.....	207
Advisory cases.....	15
Hours shop treatment.....	1,254

#### Field Work

Children's hospital—work organized—average number of patients.....	120
Home for little wanderers—average number patients—2 afternoons a week.....	10
Supervised training of B. S. O. T. student aides in District and Curative Work Shop.....	
Called in consultation on general O. T. work.....	2 hospitals

#### Patients Discharged

Discharged.....	11
Transferred to hospitals after observation.....	8
Moved from state or away for summer.....	14
Too ill to continue treatment.....	3
Transferred to commission for blind.....	2
Transferred to bureau of occupational therapy.....	4
Housework planned to fill need.....	7
Returned to school.....	11
Transferred to vocational training.....	1
Returned to work.....	10
Transferred to proper organization.....	1
<b>Total</b> .....	<b>72</b>

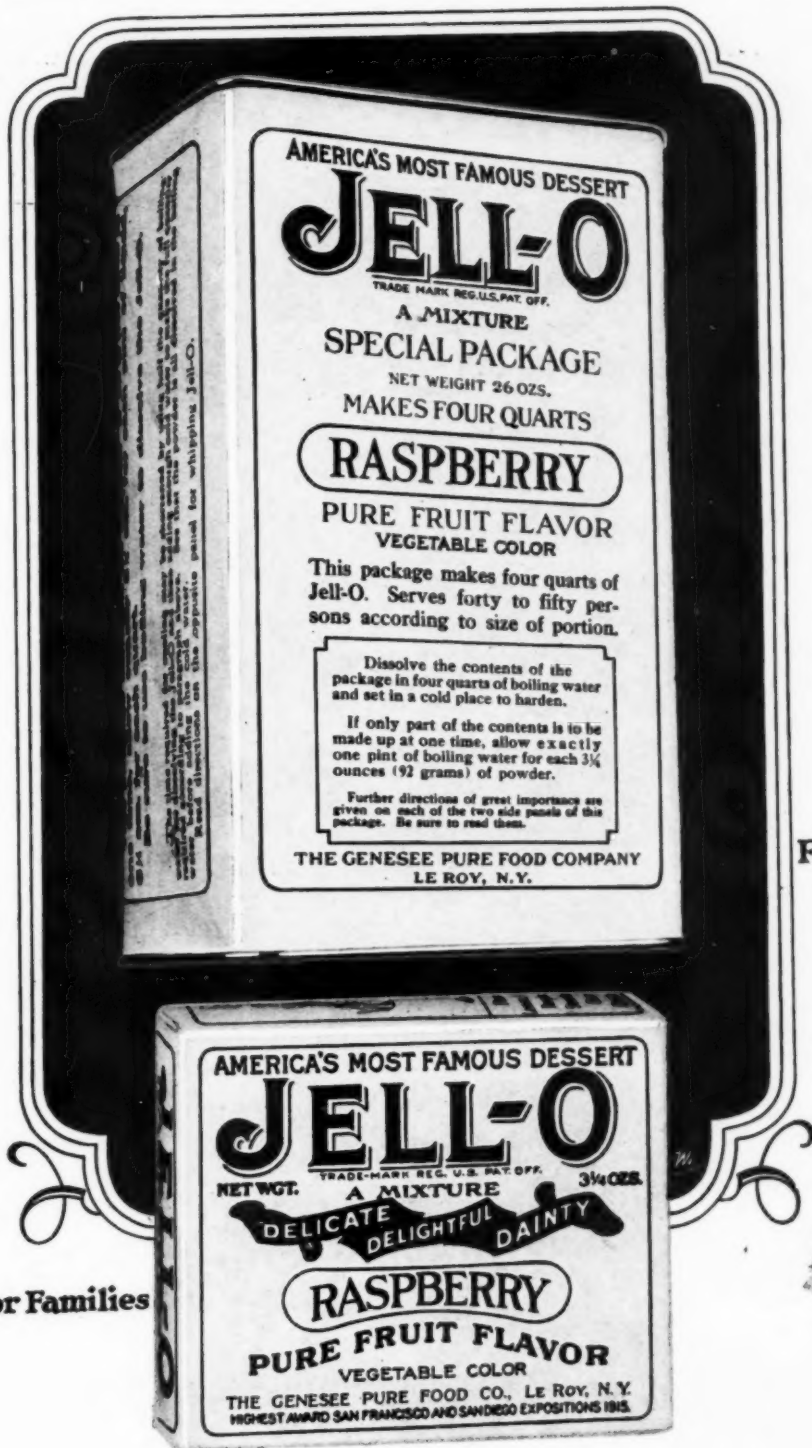
### REPORT FOR MONTH OF MARCH, 1923.

No. district calls made.....	135	O. T. in children's hospital.	
No. business calls made.....	10	One aide's services two half days a week.	
No. hours shop treatments.....	429	Disposition of Discharged Patients.	
No. advisory cases.....	10	Returned to former work..	2
No. requests for O. T. treatment.....	20	Returned to school.....	1
No. patients on waiting list..	8	Started vocational training.	2
Field Work: Organization of			

### TOTAL REPORT DEPT. OF DISTRICT AND CURATIVE WORK SHOP

		Sources																				Shop		District		Total	
		District Nursing	Mass. Gen. Hospital	Am. Red Cross	Family Welfare	Children's Hospital	P. B. Brigham Hospital	City Hospital	Public Welfare	Boston Dispensary	Veterans' Bureau	Dr. F. C. Hall	Newton Welfare	Boston State Hospital	R. Brigham Hospital	Fed. Mutual Ins. Co.	Amer. Mut. Ins. Co.	Little Wanderers	Brookline Friendly	Jewish Welfare	Other Sources						
No. patients March 1.....		7	5	1	1		1	1	1	1	3	1	1	1	1	3	7	1			9		17	28	45		
No. patients enrolled during month.....		1	1			1		1			3						4		1	1			9	4	13		
No. patients discharged during month.....											1						3				1		3	2	5		
No. patients April 1.....		8	6	1	1	1	1	2	1	1	5	1	1	1	1	3	8	1	1	1	8		23	30	53		





For Families

This is the Big Brother of the well known Jell-O package. The big box holds a larger quantity of the same Jell-O that all good housekeepers use and all families enjoy. Hotels, restaurants, hospitals, schools, camps and institutions will find it convenient and economical to use this Institutional Size, to serve their patrons with Jell-O --- "America's Most Famous Dessert"

For Institutions



Apple Snow  
Send for recipe book

# JELL-O

### Product Secondary to Curative Results

The work is purely scientific and no remuneration is received by the patient. *The product is at all times secondary to the therapeutic results.* There is no definite rule in regard to the article made by the patient. In most cases, the psychological effect of having the article to keep or to give away makes the treatment more complete. In some cases it is advisable that every other article made by the patient be returned to the department to be sold and help cover expense of materials. In this case the burden of selling the article never comes on the aides, limiting their time with the patients, but such articles are sold through the bureau of occupational therapy, now a branch of the Massachusetts Association for Occupational Therapy.

#### First Fiscal Year FINANCIAL REPORT—SPECIAL ACCOUNT DISTRICT AND CURATIVE WORK SHOP DEPARTMENT Sept. 1, 1921—Sept. 1, 1922

Receipts	
Balance Sept. 1, 1921.....	\$ 15.88
Gifts (Rummage sale \$4,000.00; Miscellaneous \$519.75).....	4,519.75
Special cases—treatment.....	64.50
Materials.....	28.70
Articles sold.....	191.07
Interest.....	4.92
	<b>\$4,824.82</b>
Expenses	
Salaries (2) (Head aide, \$1,700.00).....	\$2,843.00
Materials.....	383.52
Permanent equipment.....	75.13
Stationery.....	21.96
Incidentals.....	2.47
District cases (Exceptional cases where articles were sold through bureau and money returned to patients).....	107.65
	<b>\$3,433.73</b>
Balance Sept. 1, 1922.....	1,391.09
	<b>\$4,824.82</b>

#### DISTRICT AND CURATIVE WORK SHOP DEPARTMENT

January 1, 1922, to January 1, 1923	Shop	District	Total
Number patients enrolled Jan. 1, 1922.....	7	35	42
Number patients enrolled during year.....	22	62	84
Number patients discharged during year.....	17	56	73
Number patients enrolled Jan. 1, 1923.....	12	41	53
(Patients from 26 organizations, five doctors and other sources.)			
Number calls made on district cases during year.....			1,592
Business calls.....			109
Number hours shop treatments.....			1,552
Number requests for aide service.....			129

#### Field Work

Supervision of students' district training.  
Direction of curative work at N. E. home for little wanderers.

#### Disposition of Discharged Patients

Refused treatment.....	3
Calls out of state.....	1
Moved from city.....	5
Died.....	1
Too ill for occupational therapy.....	1
Transferred to blind committee.....	1
Transferred to hospitals.....	11
Returned to jobs.....	13
Returned to school.....	10
Returned to commercial work.....	10
Complete discharge.....	6
Transferred to vocational training.....	11
	<b>73</b>

#### Records Used at Boston School of Occupational Therapy DISTRICT AND CURATIVE WORK SHOP DEPARTMENT

1. Index card—made out when patient is enrolled.
2. Prescription—made out by physician. Kept in patient's file in office.
3. Daily record of condition, treatment, etc.—Made out by aide working with patient (long hand).
4. Permanent record—typed daily with carbon for doctor. Original attached to record.
5. Record of materials used, equipment borrowed, etc. Attached to patient's record.
6. Discharge paper—last sheet of patient's record.
7. Total monthly report of department.  
Attendance kept daily for shop cases in book.

In regard to payment for treatment, there is no definite rule and each case is handled individually. Those who can pay for treatment pay what is possible; others receive free treatment as in hospital medical clinics. Insurance companies sending patients pay a flat rate per treatment which may be from one-half hour to six hours duration, as necessary for the individual patient, plus the cost of materials used.

The attached reports will give an idea of the work covered during the first two years. The financial report covers our first fiscal year.

#### BOSTON SCHOOL OF OCCUPATIONAL THERAPY, INC.

##### District and Work Shop Department

##### PATIENT'S RECORD

Name: Jones, Mary. Nationality: American. Age: 32.  
Address: 62 Broad Street, Boston.

Diagnosis: Fracture fourth metacarpal right hand, no union of bone except when site of fracture is fixed. All fingers stiff.

Prognosis: Good.

Physical condition: Good. Mental condition: Introspective.

Social history: Good family, cooperative and intelligent.

Former occupation: Weaver in a mill.

Possibility of return: Possibly.

Functional treatment and measurements desired: Increase flexion and extension all fingers, increase circulation and tone of muscles.

	Flexion X	Extension X	Assignment	Hours daily
X R Hand	L Adduction			
R Wrist	L Abduction		Light	
R Elbow	L Pronation		Active	
R Shoulder	L Supination			
R Back	L Circumduction			
R Foot	L			
R Ankle	L			
R Hip	L			
R Knee	L			

Limitations or cautions in work: Watch for local heat with swelling and pain. Decrease work if this occurs. Grade patient in time having frequent rest periods.

Signed: FRANK D. BOND, M.D.,  
Duchess Hospital.

Date: January 1, 1923.

Every patient must have this prescription made out before the patient can be enrolled in the department.

#### DISTRICT DEPARTMENT, JANUARY 1, 1923

##### Patients now enrolled from

Angier Chemical Co.	Jewish Welfare Society
Boston Dispensary Out-Pt.	Mass. Gen. Hos. Out-Pt.
Boston State Hos. Out-Pt.	Peter Bent Brigham Hos.
Bulfinch Church	Psychopathic Hos. Out-Pt.
Bureau of Occ. Therapy	Public Welfare Soc.
Children's Aid Society	Red Cross branches
Children's Hospital Out-Pt.	South End Settlement
City Hospital Out-Pt.	St. Com. for Blind
District Nursing Assn.	St. Dept. of Rehabil.
Family Welfare Assn.	St. Ind. Accident Bd.
Federal Insurance Co.	U. S. Vets. Bureau
Harvard Ind. Hygiene Clinic	Walworth Mfg. Co.

##### Individual Doctors sending Patients

Dr. John D. Adams, Dr. Howard Crawford, Dr. Frank B. Granger,  
Dr. Walter Reed, Dr. M. N. Smith-Peterson, Dr. Robert Swift.

Name: Jones, Mary			No. 1
Date	Hour	Condition	Work done between visits and remarks:
1-2-23	10-12	Hand swollen, some pain, no local heat.	
			BASKETRY
			Basketry for increasing flexion

**BASKETRY**  
Basketry for increasing flexion and extension of fingers and increasing circulation in hand and muscle tone. Rest periods every 10 minutes.

1-3-23	10-12	Less swelling, some pain	
--------	-------	--------------------------	--

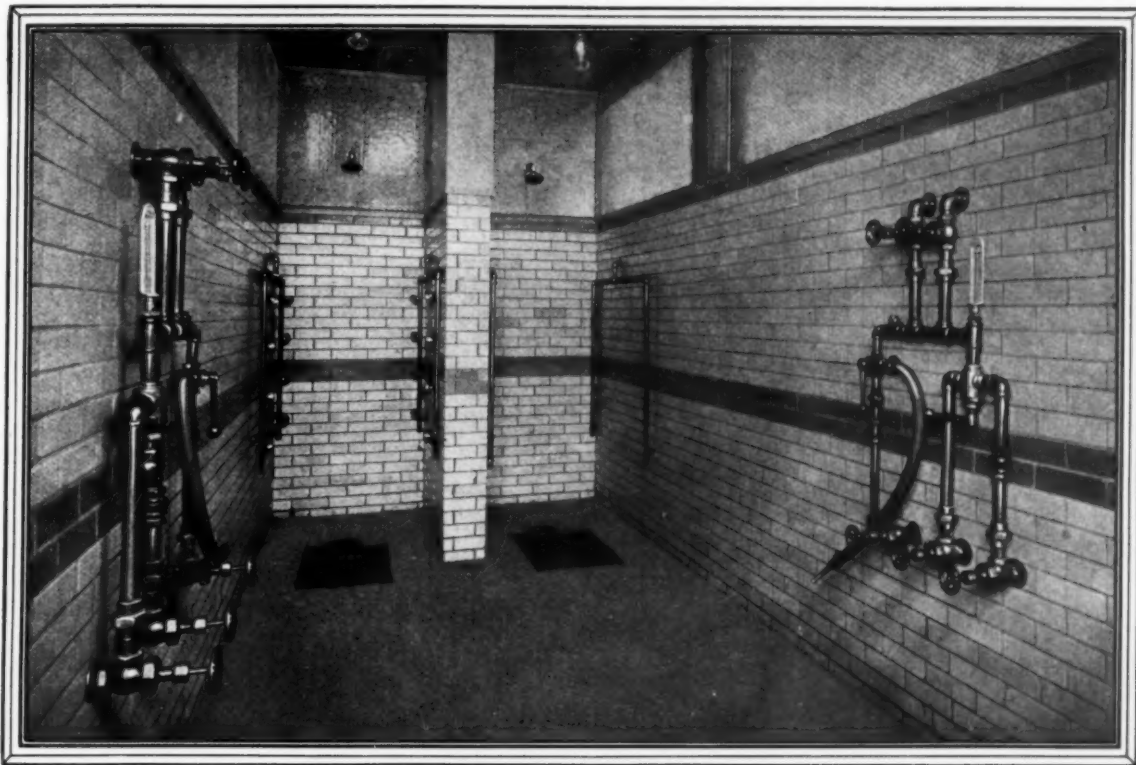
**BASKETRY AND MODELING**  
One hour spent on modeling and one on basketry with rest every fifteen minutes. Courage improved.

1-4-23	9:30-12	Less pain.	
--------	---------	------------	--

**BASKETRY AND MODELING**  
Improvement shown in flexion and extension and in circulation.

Daily record. This record is typed in duplicate from the material furnished by the aide on slip No. 3. Slip No. 3 is returned to the aide. The original of No. 4 is fastened to the patient's record in the office of the director and the carbon is sent to the doctor weekly or monthly as seems advisable.





A CRANE-EQUIPPED HYDRO-THERAPEUTIC SHOWER ROOM IN THE GLENDALE SANITARIUM, GLENDALE, CALIFORNIA. ALFRED PRIEST IS THE ARCHITECT. THE PLUMBING CONTRACTOR IS P. E. SWANSON

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In the supply of special equipment for hydro-therapeutic treatment, Crane service is as adequate and dependable as when it meets the common needs of plumbing for bathroom, operating-room or kitchen. Crane designers are guided by a wealth of varied experience gained through co-operation with specialists from all parts

of the land. They have at their command the vast production facilities of six great Crane factories. And they have the great advantage of being in touch with every new development in valves and piping specialties so that they can always give you the most recent improvements in devices for the control of steam and water.

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### Aims Simply to Hasten Recovery

In brief, then, the aim of the District and Curative Work Shop Department as conducted by the Boston School of Occupational Therapy is to follow absolutely Dr. Pattison's definition: "Occupational therapy is any activity mental or physical, definitely prescribed and guided, for the distinct purpose of contributing to and hastening recovery from disease or injury."

Name: *Jones, Mary.* Department: *Shop*  
 Date entered: *Jan. 1, 1923* Date discharged: *Jan. 30, 1923*  
 Results of treatment: *Increased flexion and extension of fingers, better circulation and muscle tone improved.*  
 Reason for discharge: *Able to return to work.*  
 Discharged to: *Former position in Dales Cloth Mill, Exeter, Mass. Working on same machine as formerly.*

Discharge slip, last sheet of patient's record.

Name: <i>Jones, Mary.</i>			No. 1	
Materials taken	Cost	Equipment	Charge to	Aide
Jan. 1, 1923				
Base for basket	\$0.20	Cutters	Patient	H. Smith
Reed	.25	Awl		
Jan. 3, 1923	.10		Patient	H. Smith
Clay				
Jan. 4, 1923	.15	Cutters returned	Patient	H. Smith
Reed				

Name: *Jones, Mary.* Date: *Jan. 2, 1923.* Hour: *10-12*  
 Condition: *Hand swollen, some pain, no local heat.*  
 Work done between visits: *Basketry.*  
 Remarks: *Basketry for flexion and extension of fingers and increasing circulation and muscle tone.*  
 Materials taken: Cost  
*Base for basket.....\$0.20*  
*Reed, 1/4 lb......25*  
*\$0.45*  
 Equipment: *Cutters, Awl.*  
 Charge to: *Patient.* Aide: *H. Smith.*

Slip made out daily by the aide; handed in at the office of the director every night. It is returned to the aide after it is copied on permanent record.

Work done between visits  
 Type of work: *Basketry; modeling.*  
 Curative progress  
 Remarks: *Watch for pain and swelling with local heat. Discontinue work if this occurs.*  
 Name: *Jones, Mary* Department: *Shop*  
 Address: *62 Broad Street, Boston*  
 Former Occupation: *Weaver in mill*  
 Possibility of returning: *Possible*  
 Date entered: *Jan. 1, 1923* Dropped:.....  
 Disability .....  
 Suggested by: *Duchess Hospital*  
 Doctor: *Frank D. Bond, M.D.*  
 Aide: *H. Smith*  
 Hours visited: *1-3*

Card in index in office of director.

### THE ROLL CALL

#### Illinois

On July 18, forty members of the Illinois Society of Occupational Therapists visited the occupational therapy department of the Great Lakes Naval Training Station Hospital, Great Lakes, which is in charge of Mrs. Abbey, head aide. The program for the afternoon began with a tour of the main hospital building.

In one unit of the institution is the Red Cross House where the regular meeting was held at which Dr. Ross, reconstruction officer, spoke on the value of occupational therapy work in the treatment of nervous cases.

After the meeting the shop was visited. The shop is of unusual interest because of the artistic setting of products such as baskets, ferneries, vases, pottery, and against a background of cream colored wall trimmed with blue. This is one of the few hospitals with a fully equipped pottery room. Each one of the workers seemed intent on some particular problem.

#### Michigan

The work done by patients in the occupational therapy departments in hospitals in Detroit and vicinity was placed on exhibition at the biennial nurses' convention held in Detroit June 16-21.

Five student therapists from the training class at Cass High School, Detroit, are doing practice work in occupational therapy in Detroit hospitals for the summer.

#### Minnesota

Dr. W. K. Foley, chief of medical service, U. S. Veterans' Hospital, No. 68, Minneapolis, read a paper before the Duluth Association of Occupational Therapy on May 6, on the subject "Fatigue and Psychology as Factors in Occupational Therapy."

Miss Sydney Boteler of Minneapolis gave a series of talks before the Junior League of Minneapolis on occupational therapy. The Junior League Organization is working with shut-ins in cooperation with the visiting nurse association.

Patients at the U. S. Veterans' Hospital, No. 65, St. Paul, made about 45,000 poppies for the Memorial Day poppy sale, supplying among others those sold by the American Legion in St. Paul, South St. Paul and Rochester, Minn.

Miss Catherine Boteler, reconstruction aide at U. S. Veterans' Hospital No. 68 Minneapolis, was married April 28 at All Saints Episcopal Church to Dr. Paul William Giessler, orthopedic surgeon of Minneapolis.

Miss Mabel Kaercher was appointed occupational therapy aide at U. S. Veterans' Hospital No. 65, St. Paul.

Miss Bertha M. Holmes was transferred from Tuscaloosa, Miss., to the occupational therapy department at U. S. Veterans' Hospital No. 65, St. Paul.

#### New Jersey

Occupational therapists attended the meetings of the American Psychiatric Association at Atlantic City.

#### Pennsylvania

Exhibit of the work of the Philadelphia training school.

#### Wisconsin

Louis Goodman, director of the Junior League curative work shop is spending three months in Europe studying curative work for children and industrial accident cases. glazing.



# THE DOYLE Chlorinometer for Administering Chlorine Gas

## Giving "CHLORINOMETER" Treatments for Respiratory Diseases identifies the leading physicians in a community

The therapeutic value of chlorine gas in the treatment of respiratory diseases has been so firmly established that it is already reaching beyond the profession to the public. This fall, your own patients will be asking for this treatment. It is none too soon for you to place your "Chlorinometer" order—you will want a machine in hand to establish yourself as the progressive physician of the community.



is being bought by Physicians and Institutions everywhere because it has every desirable technical advantage, and can be used in any ordinary room for individual or group treatments.

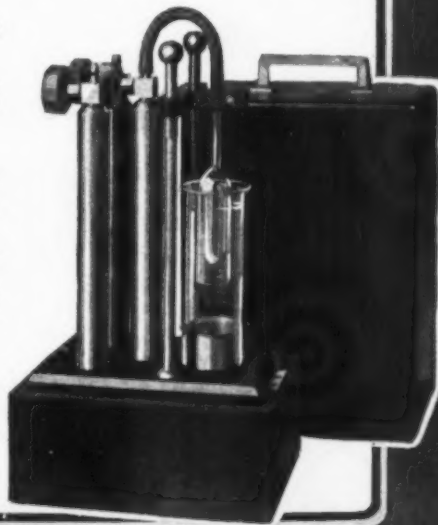
It is safe, because you can see the gas being delivered.

It is economical; 5 cents worth of gas is sufficient for a complete one hour treatment of either one patient, or a group.

It is portable, and you can use it in your patient's home, in any convenient room, and without any possible harm to its furnishings.

It is popularly priced. The Physician's Portable Model, equipped with three (3) fully charged cylinders (90 complete treatments) costs only \$60.00. Cylinders recharged at \$2.00 each.

For those who have not studied the remarkable cures reported by Drs. Vedder and Sawyer in the A. M. A. Journal, we are issuing a reprint of the article in question. A request will bring you a copy.



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17 West 60<sup>th</sup> Street, New York.

When using advertisements see Classified Index, also refer to YEAR BOOK.

## MEETINGS, CONVENTIONS AND CONFERENCES

### PROGRAM FOR A. H. A. BUFFALO CONFERENCE NEARS COMPLETION

**T**HE program for the twenty-sixth annual conference of the American Hospital Association to be held in Buffalo, N. Y., October 6-10, is now ready for announcement in practically its final form.

As previously indicated, the sessions will be held in the 106th Armory where registration will take place Monday morning, October 6 from 9 a. m. to 2:30 p. m., in the lobby. The exposition will be held in the drill hall of the armory.

The first section meetings will be held at 2:30 Monday afternoon and the first general session at 8 o'clock Monday night in the ball room of the Statler Hotel.

The program follows:

#### Monday Afternoon, 2:30 to 4:00 P. M.

##### SMALL HOSPITAL SECTION

Theatre of Armory

Chairman, Miss Charlotte Jane Garrison, superintendent, Polk County Hospital, Des Moines, Iowa; Secretary, Miss Myral M. Sutherland, superintendent, Mary McClellan Hospital, Cambridge, N. Y.

- (1) Paper—Tuberculosis and the Small Hospital...2:30  
By T. B. Kidner, institutional secretary, National Tuberculosis Association, New York, N. Y.
- (2) Paper—One Solution for Bringing Metropolitan Services to Small Country Communities .....2:55  
By Denver M. Vickers, M.D., Mary McClellan Hospital, Cambridge, N. Y.
- (3) Round-table conference conducted by Miss G. Gruver, superintendent, Davis Hospital, Pine Bluff, Ark.....3:20  
Topics for Discussion: (a) securing of probationers, (b) educational standards for nurses, (c) allowances to nurses while in training, (d) training school affiliation, (e) personnel for a fifty-bed hospital, (f) purchasing, (g) laboratory fees, (h) case records.
- (4) General Discussion.

#### Monday Afternoon, 2:30 to 4:00 P. M.

##### OUT-PATIENT SECTION

Ball Room of Armory

Chairman, Frank E. Wing, director, Boston Dispensary, Boston, Mass.; Secretary, Boris Fingerhood, superintendent, United Israel-Zion Hospital, Brooklyn, N. Y.

- (1) Report of the Out-Patient Committee.....2:30  
Chairman, Alec N. Thomson, M.D., chairman, medical secretary, Committee on Dispensary Development, 15 West 43rd Street, New York, N. Y.
- (2) Opportunities for Health Education in Out-Patient Clinics .....3:00  
To be discussed from the point of view of:  
(a) the public school, (b) the public

health officer, (c) the general medical practitioner, (d) the dispensary or out-patient clinic.

- (3) General discussion.

#### Monday Evening, 8:00 to 10:00 P. M.

##### OPENING GENERAL SESSION

Ball Room Statler Hotel

President MacEachern, Presiding

- (1) Invocation ..... 8:00
- (2) Address of welcome..... 8:05
- (3) Response to the address of welcome..... 8:10  
Daniel D. Test, trustee of the association, superintendent, Pennsylvania Hospital, Philadelphia, Pa.
- (4) Address of the president.....8:15  
Malcolm T. MacEachern, M.D., Chicago, Ill.
- (5) Report of the trustees.....8:35  
Read by Richard P. Borden, senior trustee, Union Hospital, Fall River, Mass.
- (6) Report of the treasurer.....(Printed)  
Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill.
- (7) Report of the executive secretary.....8:50  
A. R. Warner, M.D., executive secretary, Chicago, Ill.
- (8) Report of the membership committee.....9:05  
Report of progress in the general membership campaign, Chairman, Lewis A. Sexton, M.D., Hartford Hospital, Hartford, Conn.
- (9) The Hospitals and the Workmen's Compensation Laws .....9:15  
John A. Lapp, director, Department of Social Action, National Catholic Welfare Council, Chicago, Ill.
- (10) Hospital Publicity .....9:30  
Ralph W. Keeler, counsellor in publicity, Board of Hospitals and Homes of the Methodist Episcopal Church, New York, N. Y.
- (11) Our Responsibility to the American Hospital Association .....9:50  
Robert Jolly, superintendent, Baptist Hospital, Houston, Texas.

#### Tuesday Morning, 9:30 to 11:00 A. M.

##### GENERAL SESSION

Theatre of Armory

The reports of most of the technical committees of the association will be officially presented at this session by the various chairmen briefly but emphasizing the essentials of the report, then referred by the president to the appropriate sections for full consideration and discussion.

President MacEachern, Presiding

- (1) Report of the intern committee.....(Printed)  
Chairman, Nathaniel W. Faxon, M.D., super-



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Out of a Glass"**



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**CLEAR IN COLOR—SMOOTH BOTTOM**

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**Wheeling, W. Va.**

- intendent, Strong Memorial Hospital, Rochester, N. Y.  
Referred to the administration section Tuesday afternoon for discussion and made a special order for 2:30 p. m.
- (2) Report of the committee on buildings—construction, equipment and maintenance. (Printed)  
Chairman, S. S. Goldwater, M.D., director, Mount Sinai Hospital, New York, N. Y.  
Referred to the construction section Thursday afternoon for discussion and made a special order for 2:30 p. m.
- (3) Report of the committee on foods and equipment for food service. (Printed)  
Chairman, F. R. Nuzum, M.D., director, Santa Barbara Cottage Hospital, Santa Barbara, Calif.  
Referred to the dietetic section Tuesday afternoon for discussion and made a special order for 2:30 p. m.
- (4) Fourth report of the committee on accounting and records. (Printed)  
Chairman, A. C. Bachmeyer, M.D., superintendent, Cincinnati General Hospital, Cincinnati, Ohio.  
Referred to the administration section Tuesday afternoon for discussion and made a special order for 3:15 p. m.
- (5) Report of the special committee on cleaning. (Printed)  
Chairman, C. W. Munger, M.D., superintendent, Grasslands Hospital, Valhalla, N. Y.  
Referred to the administration section Wednesday afternoon for discussion and made a special order for 2:30 p. m.
- (6) Report of committee on clinical and scientific equipment and work. (Printed)  
Chairman, K. H. Van Norman, M.D., superintendent, Charles T. Miller Hospital, St. Paul, Minn.  
Referred to the administration section Wednesday afternoon for discussion and made a special order for 3:00 p. m.
- (7) Report of committee on general furnishings and supplies. (Printed)  
Chairman, Miss Margaret Rogers, R.N., superintendent, LaFayette Home Hospital, LaFayette, Ind.  
Referred to the administration section Wednesday evening for discussion and made a special order for 8:00 p. m.
- (8) Report of out-patient committee. (Printed)  
Chairman, Alec N. Thomson, M.D., medical secretary, committee on dispensary development, 15 W. 43rd St., New York, N. Y.  
Referred to the out-patient section Monday afternoon for discussion and made a special order for 2:30 p. m.
- (9) Report of committee on relation of hospitals to public health activities. (Printed)  
Chairman, Albert S. Hyman, M.D., superintendent, Beth David Hospital, New York, N. Y.  
Referred to the administration section Tuesday afternoon for discussion and made a special order for 3:45 p. m.
- (10) Report of the committee on the training of the hospital administrator. (Printed)  
Chairman, F. A. Washburn, M.D., director, Massachusetts General Hospital, Boston, Mass.  
Referred to the administration section, Wednesday evening and made a special order for 8:25 p. m.
- (11) Report of the legislative committee. (Printed)  
Chairman, E. T. Olson, M.D., superintendent, Englewood Hospital, Chicago, Ill.  
Referred to the administration section Wednesday evening for discussion and made a special order for 8:50 p. m.
- (12) Report of the committee on building codes. (Printed)  
Chairman, Charles F. Owsley, Cuyahoga Bldg., Cleveland, Ohio.  
Referred to the construction section Thursday afternoon for discussion and made a special order for 3:30 p. m.
- (13) Report of the committee on training school budgets. (Printed)  
Chairman, George O'Hanlon, M.D., general medical superintendent, Bellevue and Allied Hospitals, New York, N. Y.  
Referred to the nursing section Wednesday evening for discussion and made a special order for 8:00 p. m.
- (14) Report of the committee on cancer control. (Printed)  
Chairman, Ernest P. Boas, M.D., medical director, Montefiore Hospital, New York, N. Y.  
Referred to the administration section Wednesday evening for discussion and made a special order for 9:10 p. m.
- (15) Committee on the relation of governmental bureaus and departments to hospitals. (Printed)  
Chairman, Clarence E. Ford, superintendent, division of medical charities, New York Board of Charities, Albany, N. Y.  
Referred to the administration section Wednesday evening for discussion and made a special order for 9:30 p. m.
- (16) Report of Hospital Library and Service Bureau. (Printed)  
Miss Donelda R. Hamlin, director, Chicago, Ill.
- (17) Report of the nominating committee. 9:30  
Chairman, C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.  
Appointment of election tellers by the president.
- (18) The relation and responsibility of the general hospital in the care and treatment of the special groups of patients. 9:45  
(a) Tuberculosis—H. A. Pattison, M.D., supervisor, Medical Service, National Tuberculosis Association, 370 Seventh Ave., New York, N. Y.  
(b) Psychiatric—William C. Sandy, M.D., director, Bureau of Mental Health, Harrisburg, Pa.  
(c) Incurable—Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis.
- (19) General Discussion. 10:45  
Tuesday Afternoon, 2:30 to 4:00 P. M.
- ADMINISTRATION SECTION**  
Theatre of Armory  
Chairman, Ralph B. Seem, M.D., director, Albert Merritt Billings Hospital, Chicago, Ill.; secretary, S. R. Johnston, superintendent, Grady Hospital, Atlanta, Ga.
- (1) Report of the intern committee. 2:30  
Chairman, Nathaniel W. Faxon, M.D., superintendent, Strong Memorial Hospital, Rochester, N. Y.
- (2) Report of the committee on accounting and records. 3:15  
Chairman, A. C. Bachmeyer, M.D., superintendent, Cincinnati General Hospital, Cincinnati, Ohio
- (3) Report of the committee on relation of hospitals to public health activities. 3:45  
Chairman, Albert S. Hyman, M.D., superintendent, Beth David Hospital, New York, N. Y.
- Tuesday Afternoon, 2:30 to 4:00 P. M.
- DIETETIC SECTION**  
Ball Room of Armory  
Chairman, Miss Lulu G. Graves, supervising dietitian, Mt. Sinai Hospital, New York, N. Y.; secretary, Miss Marion Peterson, dietitian, Miami Valley Hospital, Dayton, Ohio.
- (1) Report of the committee on foods and equipment for food service. 2:30  
Chairman, F. R. Nuzum, M.D., director, Santa Barbara Cottage Hospital, Santa Barbara, Calif.  
Discussion opened by C. G. Parnall, M.D., medical director, Rochester General Hospital, Rochester, N. Y.
- (2) The Economy of Modern Methods in Study and Treatment of Diabetes. 3:00



# The Hospital and Acidosis

THE community health protection given by the hospital and its out-patient department, may well include education of the public toward the prevention as well as the correction of acidosis.

Acidosis is a forerunner of so many serious organic troubles that its correction or prevention comes naturally within the field of the health protection service which today is generally accepted as a part of the hospital's function. Furthermore acidosis becomes more particularly a problem of the hospital because so frequently the condition is recognized for the first time when the patient enters the institution for diagnosis and treatment of some other ailment.

Whatever may be the underlying cause the simple corrective treatment here discussed should be considered by those responsible for the treatment and care of patients in hospitals and similar institutions.

The increasing use of sodium bicarbonate by the public to control "acid stom-

ach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

## DOSAGE

The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.). This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.). The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

## PHILLIPS' Milk of Magnesia

**CAUTION.** Beware of imitations of Phillips' Milk of Magnesia. The genuine product bears our registered trade-mark. Kindly prescribe in original 4-ounce (25c bottles) and 12-ounce (50c bottles) obtainable from druggists everywhere.

*Prepared only by*

**The Charles H. Phillips Chemical Co., New York and London**

When using advertisements see Classified Index, also refer to YEAR BOOK.

George Baehr, M.D., Mount Sinai Hospital,  
New York, N. Y.

Discussion opened by John R. Williams, M.D.,  
Highland Hospital, Rochester, N. Y.

- (3) Unified Dietary Service of a Hospital.....3:30  
Kate Daum, Ph.D., Presbyterian Hospital,  
New York, N. Y.

**Tuesday Evening, 8:00 to 10:00 P. M.**

#### DINNER GENERAL SESSION

Ball Room Statler Hotel

President MacEachern, Presiding

- (1) Introduction of representatives from foreign  
countries.  
(2) Address—Hospital Origins, S. S. Goldwater,  
M.D., director, Mount Sinai Hospital, New  
York, N. Y.

**Wednesday Morning, 9:30 to 11:00 A. M.**

#### GENERAL SESSION

Theatre of Armory

President MacEachern, Presiding

- (1) The Hospital in Relation to the Health De-  
partment .....9:30  
Henry A Rowland, secretary, Department of  
Health, Toronto, Ontario.

- (2) Round-table conference conducted by Joseph C.  
Doane, M.D., superintendent, Philadelphia  
General Hospital, Philadelphia, Pa. ....10:00

Topics for discussion:

- (a) The per capita cost and its value as a  
comparative unit in hospitals, (discussion  
opened by A. C. Bachmeyer, M.D., superin-  
tendent, Cincinnati General Hospital, Cin-  
cinnati, Ohio); (b) the hospital in relation  
to the community needs; (c) unit cost of  
hospital services; (d) economies in hospi-  
tals; (e) securing and keeping interns;  
(f) organizing and managing the out-pa-  
tient department of a hospital; (g) func-  
tions of medical social service department  
in a hospital; (h) filing and use of case  
records; (i) humanizing and popularizing  
the hospital; (j) improving the nurse's  
training; (k) hospital supplies and central  
service system; (l) reducing fire hazards  
in hospitals.

**Wednesday Afternoon, 2:30 to 4:00 P. M.**

#### ADMINISTRATION SECTION

Theatre of Armory

Chairman, Ralph B. Seem, M. D., director, Albert Mer-  
ritt Billings Hospital, Chicago, Ill.; secretary, S. R. Johns-  
ton, superintendent, Grady Hospital, Atlanta, Ga.

- (1) Report of the committee on cleaning.....2:30  
Chairman, C. W. Munger, M.D., superintend-  
ent, Grasslands Hospital, Valhalla, N. Y.

- (2) Report of the committee on clinical and scien-  
tific equipment and work.....3:00  
Chairman, K. H. Van Norman, M.D., super-  
intendent, Charles T. Miller Hospital, St.  
Paul, Minn.

- (a) Report of sub-committee on diabetes—  
its treatment by insulin, Franklin R. Nu-  
zum, M.D., director, Santa Barbara Cot-  
tage Hospital, Santa Barbara, Calif.

Discussion opened by Walter S. Goodale,  
M.D., director, Buffalo City Hospital, Buf-  
falo, N. Y.

- (b) Report of sub-committee on physio-  
therapy in hospitals, Charles E. Stewart,  
M.D., associate medical director, Battle  
Creek Sanitarium, Battle Creek, Mich.

- (c) Report of sub-committee on labora-  
tories in hospitals, S. G. Davidson, super-  
intendent, Butterworth Hospital, Grand  
Rapids, Mich.

**Wednesday Afternoon, 2:30 to 4:00 P. M.**

#### TRUSTEE SECTION

Ball Room of Armory

Chairman, Henry J. Fisher, president, Manhattan Eye,  
Ear and Throat Hospital, New York, N. Y.; secretary,  
W. M. Gartshore, trustee, Victoria Hospital, London, On-  
tario.

- (1) Report of the committee of trustee section....2:30  
Henry J. Fisher, President, Manhattan Eye,  
Ear and Throat Hospital, New York, N. Y.  
Discussion of report.

- (2) Hospital Organization from the Point of View  
of the Medical Staff.....2:50  
David L. Edsall, M.D., dean of Harvard Col-  
lege of Medicine, Cambridge, Mass.

- (3) Hospital Organization from the Point of View  
of Community Relations, Including the  
Out-Patient Department, etc.....3:10  
Sidney L. Schwartz, trustee, Michael Reese  
Hospital, Chicago, Ill.

- (4) Hospital Organization from the Point of View  
of Community Support.....3:30  
William J. Norton, general secretary, Detroit  
Community Chest, Detroit, Mich.

- (5) General discussion .....3:50

**Wednesday Evening, 8:00 to 10:00 P. M.**

#### ADMINISTRATION SECTION

Theatre of Armory

Chairman, Ralph B. Seem, M.D., director, Albert Mer-  
ritt Billings Hospital, Chicago, Ill.; secretary, S. R. Johns-  
ton, superintendent, Grady Hospital, Atlanta, Ga.

- (1) Report of the committee on general furnish-  
ings and supplies.....8:00

Chairman, Miss Margaret Rogers, R.N., su-  
perintendent, LaFayette Home Hospital,  
LaFayette, Ind.

- (2) Report of the committee on the training of the  
hospital administrator .....8:25

Chairman, F. A. Washburn, M.D., director,  
Massachusetts General Hospital, Boston,  
Mass.

- (3) Report of the legislative committee.....8:50

Chairman, E. T. Olson, M.D., superintendent,  
Englewood Hospital, Chicago, Ill.

- (4) Report of the committee on Cancer control....9:10

Chairman, Ernest P. Boas, M.D., medical di-  
rector, Montefiore Hospital, New York,  
N. Y.

- (5) Committee on the relation of governmental bu-  
reaus and departments to hospital.....9:30

Chairman, Clarence E. Ford, superintendent,  
division of medical charities, New York  
Board of Charities, Albany, N. Y.

- (6) General discussion .....9:50

**Wednesday Evening, 8:00 to 10:00 P. M.**

#### NURSING SECTION

Ball Room of Armory

Chairman, Miss Jean I. Gunn, R.N., superintendent,  
nurses, Toronto General Hospital, Toronto, Ontario;  
secretary, Miss Shirley Titus, superintendent of nurses,  
Columbia Hospital, Milwaukee, Wis.

- (1) Report of the committee on training school  
budgets .....8:00

Chairman, George O'Hanlon, M.D., general  
medical superintendent, Bellevue and Allied  
Hospitals, New York, N. Y.

- (2) To What Extent Should a Hospital Depend  
on the Students of the School of Nursing  
for the Nursing Service of the Hospital?...8:30

Helen Wood, director, School of Nursing,  
Strong Memorial Hospital, Rochester, N. Y.

- (3) The Relationship of the Superintendent of  
Nurses to the Board of Trustees.....9:00

Mrs. Carl H. Davis, chairman, Training  
School Committee and Member Board of  
Trustees, Columbia Hospital, Milwaukee,  
Wis.

Discussion opened by Miss Ada Belle Mc-  
Cleery, R.N., superintendent, Evanston  
Hospital, Evanston, Illinois.

- (4) Is the Preparation of the Student Nurse for  
Special Branches of Nursing the Responsi-  
bility of the Training School?.....9:30

**Thursday Morning, 9:30 to 11:00 A. M.**

#### GENERAL SESSION

Theatre of Armory

President MacEachern, Presiding

- (1) The Teaching Function of a Hospital.....9:30  
(a) Some Special Problems of Teaching





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**DO YOU KNOW** that the many kinds of tea you hear called by numerous names may all come from the same bush? That the position of the leaf on the stem determines its grade? That tea is black or green simply according to the method of "curing" the leaves?

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Spices  
Gelatine  
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Flavoring  
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Pudding  
Powders  
Marshmallow  
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Hospitals, John A. Hornsby, M.D., superintendent, University of Virginia Hospital, Charlottesville, Va.

- (b) Possibilities of Post-Graduate Instruction by Non-Teaching Hospitals..... 9:50  
W. P. Morrill, M.D., superintendent, Shreveport Charity Hospital, Shreveport, La.

- (c) The Hospital as a Teaching Center for Nursing ..... 10:10  
Miss Adda Eldredge, R.N., president, Bureau of Nursing Education, Madison, Wis.

- (d) Observation Courses for Hospital Executives ..... 10:30  
John M. Smith, superintendent, Hahnemann Hospital, Philadelphia, Pa.

- (2) General discussion ..... 10:50

Thursday Afternoon, 2:30 to 4:00 P. M.

#### SOCIAL SERVICE STATION

Theatre of Armory

Chairman, Miss Ida M. Cannon, director, Social Service Department, Massachusetts General Hospital, Boston, Mass.; secretary, Miss Lena R. Waters, American Association of Hospital Social Workers, Johns Hopkins Hospital, Baltimore, Md.

- (1) Paper—Application of Social Service to the Problems of the Small Hospital..... 2:30  
Mrs. Martha J. Megee, social service consultant, Department of Public Welfare, Harrisburg, Pa.

- (2) Paper—The Relation of the Patients' Library to the Social Service Department..... 3:00  
Miss Perrie Jones, Public Library, St. Paul, Minn.

- (3) General discussion ..... 3:30

Thursday Afternoon, 2:30 to 4:00 P. M.

#### CONSTRUCTION SECTION

Theatre of Armory

Chairman, E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill.; secretary, O. H. Bartine, superintendent, Hospital for Deformities and Joint Diseases, New York, N. Y.

- (1) Report of committee on building—construction, equipment and maintenance ..... 2:30  
Chairman, S. S. Goldwater, M.D., director, Mount Sinai Hospital, New York, N. Y.

- (2) Planning and construction of laboratories.... 2:50  
C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.  
Discussion opened by Robert Jolly, superintendent, Baptist Hospital, Houston, Texas.

- (3) Planning and Construction of Contagious Disease Hospital ..... 3:10  
Paul W. Wipperman, M.D., superintendent, Decatur and Macon County Hospital, Decatur, Ill.

- (4) Report of the committee on building codes... 3:30  
Chairman, Charles F. Owsley, Cuyahoga Bldg., Cleveland, Ohio.

- (5) General discussion ..... 3:50

Thursday Evening, 8:00 to 10:00 P. M.

#### GENERAL SESSION

Auditorium

President MacEachern, Presiding

- (1) What Is an Efficient Hospital?..... 8:00  
C. S. Woods, M.D., superintendent, St. Luke's Hospital, Cleveland, Ohio.

- (2) The Development of the Alameda County Hospital Plan ..... 8:30  
R. G. Brodrick, M.D., director of hospitals, Alameda County Hospital, San Leandro, Calif.

- (3) The Relation of the State and County Hospital to the Prevention and Care of Disease... 9:00  
Joseph R. Morrow, M.D., superintendent, Bergen County Hospital, Ridgewood, N. J.

- (4) General discussion ..... 9:30

Friday Morning, 9:30 to 11:00 A. M.

#### GENERAL SESSION

Theatre of Armory

President MacEachern, Presiding

- (1) The Hospitalization of Infectious Diseases... 9:30

D. L. Richardson, M.D., superintendent, Providence City Hospital, Providence, R. I.

- (2) Round-table conference conducted by Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill..... 10:00

Topics for discussion: (a) Which is the better, dressing patients in the wards or taking them to a central dressing room? (b) Do you fumigate after contagion and why? (c) Should nurses take oral orders from a physician? (d) How can our hospital beds be kept full? There is a cry for more beds all over the country and the United States census shows only about 52% occupied all the year. (e) Can high standard nursing efficiency be maintained in a hospital giving a two years' course of training? (f) Should the association have a section for woman's auxiliary boards? (g) Should general hospitals have a psychiatric department? Should we give more attention to these patients than we do? (h) Should records be kept in the dietetic department regarding the patient and diet, the same to become a part of the permanent records? (i) Should ward patients be permitted to smoke in the wards? (j) Is standardization of bed linen desirable? (k) Is it advisable to put all unpaid bills in the hands of a collector? (l) Is a water softener an economy in a hospital laundry and power plant? (m) Should economic responsibility be vested in the heads of the various departments? (n) How to account for missing articles and valuables of the patient? (o) What should be the attitude of a hospital (not a teaching hospital) towards a staff member who asks for an intern to be assigned to him exclusively and who is willing to finance this intern? (p) What is understood by an endowed room? What are the privileges of a person endowing a private room? (q) If through a mistake in diagnosis another patient contracts the disease and has to be quarantined for a period of time, is the hospital obliged to care for the patient free of charge, or should the attending physician, because of his mistake, be compelled to pay the hospital charges? (r) Is it the sense of this meeting that a school for the training of hospital executives be speeded up and should it be a university course or not? (s) Should the superintendent be invited to all staff meetings? (t) What temperature is the index between an infected and a non-infected obstetrical case?

Friday Afternoon, 2:30 to 4.00 P. M.

#### GENERAL SESSION AND BUSINESS MEETING

Theatre of Armory

President MacEachern, Presiding

- (1) The Status of the Budget in the Operation of a Hospital ..... 2:30  
Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio.

- (2) Some Fundamental Problems in Hospital Administration ..... 2:50  
E. M. Bluestone, M.D., director, Mount Sinai Hospital, New York, N. Y.

- (3) Report of election results.

- (4) Report of committee on resolutions..... 3:10  
Chairman, W. H. Conley, M.D., medical superintendent, Metropolitan Hospital, Welfare Island, N. Y.

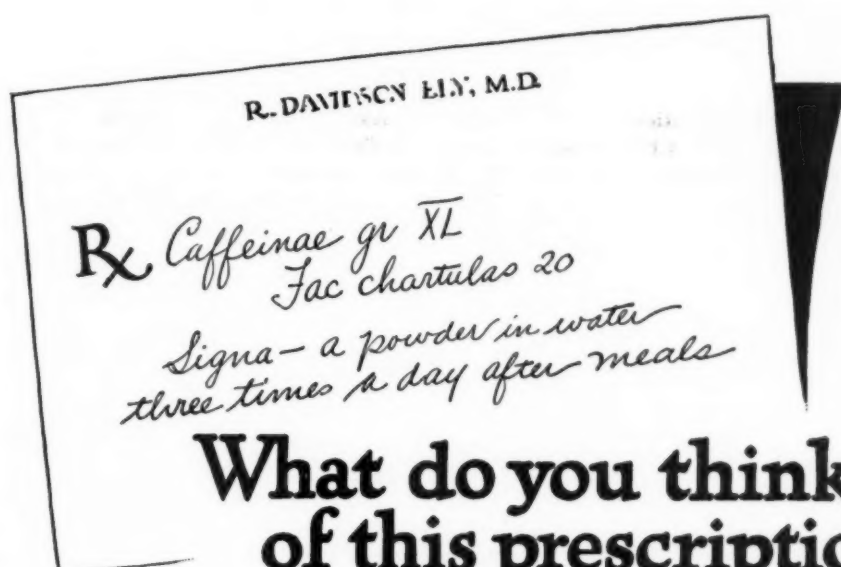
- (5) Report of the committee on constitution and rules ..... 3:15  
Chairman, Mr. Richard P. Borden, trustee, Union Hospital, Fall River, Mass.

- (6) The new president takes the chair ..... 3:20

- (7) Announcement of committee appointments for 1925.

4:00 to 6:00 p. m. Study of the exposition.





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## CANADIAN NURSES' ASSOCIATION HOLDS TWELFTH MEETING AT HAMILTON, ONT.

THE twelfth convention of the Canadian Nurses' Association was held in the auditorium of the Royal Connaught Hotel, Hamilton, Ont., June 23, 24, and 25, 1924.

This association was organized under the name of the Canadian National Association of Trained Nurses in October, 1908. At that time delegates from thirteen nurse organizations throughout Canada met in convention at Ottawa and formed the provisional organization of the association which was replaced by the permanent organization at the first meeting of the association held in 1911. The association has met in the majority of the principal cities of Canada. Meetings were held annually until 1922, since then meetings have been held biennially.

An unusually large number of delegates attended the twelfth convention in Hamilton. Thirty-seven of the fifty federated associations were represented by one or more delegates, while there was a marked increase in the attendance of members.

The program for the sessions consisted almost entirely of discussions and the settling of business matters relating to the association. The exceptions to business proceedings were on Monday evening, when a joint open session with the Canadian Association of Nursing Education was held, and on Tuesday evening when the visiting nurses were the guests of the Hamilton nurses' associations at a reception held at the nurses' residence, Hamilton General Hospital.

### Change Name of Association

The most important items of business brought to the attention of the assembly were:

(a) The suggested change in the name of the organization. By a unanimous vote the name of the organization was changed from "The Canadian National Association of Trained Nurses" to "The Canadian Nurses' Association."

(b) The increase in the provincial representation on the executive committee of the association. Formerly two representatives were elected by each province to the council of the executive committee. In future each province shall be represented by four councillors, i. e. the president, and the chairman of the nursing education, the private duty, and the public health sections or committees of the provincial associations.

(c) The decision to move the office of the *Canadian Nurse* from Vancouver, B. C., to the national office Winnipeg, Man., and to make several changes in the make-up of the magazine whereby improvements may be effected. The magazine is to be moved to Winnipeg September 1, 1924.

(d) The National Memorial Committee reported that, in the interval since the meeting in 1922, sufficient funds had been collected by Canadian nurses for the proposed memorial. This memorial is to be in honor of the early nurses of Canada, and the nursing sisters who gave their lives during the World War. The memorial is to be placed in the federal building, Ottawa, and will be unveiled at the time of the next general meeting of the association which is to be held in Ottawa.

(e) The formation of the section on nursing education, by the amalgamation of the Canadian Association of Nursing Education and the national organization.

(f) The president announced that in the interval since the last general meeting, the association had appointed an executive secretary, and had opened a national office at 609 Boyd Bldg., Winnipeg, Man. This office was opened on February 1, 1923. From the reports of the executive secretary, the executive committee were able to announce that this office was proving a satisfactory undertaking of the association.

The report of the governor of the membership committee recommended the Graduate Nurses' Association at Prince Edward Island, and the alumnae association of the Sherbrooke General Hospital, Sherbrooke, Que., to the national association as eligible for membership. The applications from these associations had been approved by the executive committee and were ratified by the general assembly.

### Progress in Nursing Education

The report of the committee on nursing progress consisted of the report of the committee's representative from each province. These reports showed that inspection of training schools had been established in several provinces; that the provincial associations of nurses had prepared a minimum standard curriculum which had been adopted by the majority of the training schools; that the standard of educational qualifications for entrance to the training schools had been raised through provincial legislation; that numerous smaller training schools had become affiliated for the course or courses for which their schools were unable to give sufficient theoretical and practical instruction to the student nurses; that the five year combined course for student nurses had been created in two more universities; that the attendance of graduate nurses at the various courses offered by the universities was increasing annually and that summer extension courses in the various branches of nursing were being conducted by the universities.

Miss C. Reimann, Denmark, secretary of the International Council of Nurses, was a guest of the association during the convention. Miss Reimann addressed the joint open session on Monday evening, speaking on "The Work of the International Council of Nurses."

Miss Alice L. Lake, University Hospital, Ann Arbor, Mich., was a representative to the convention from the Michigan State League of Nursing Education.

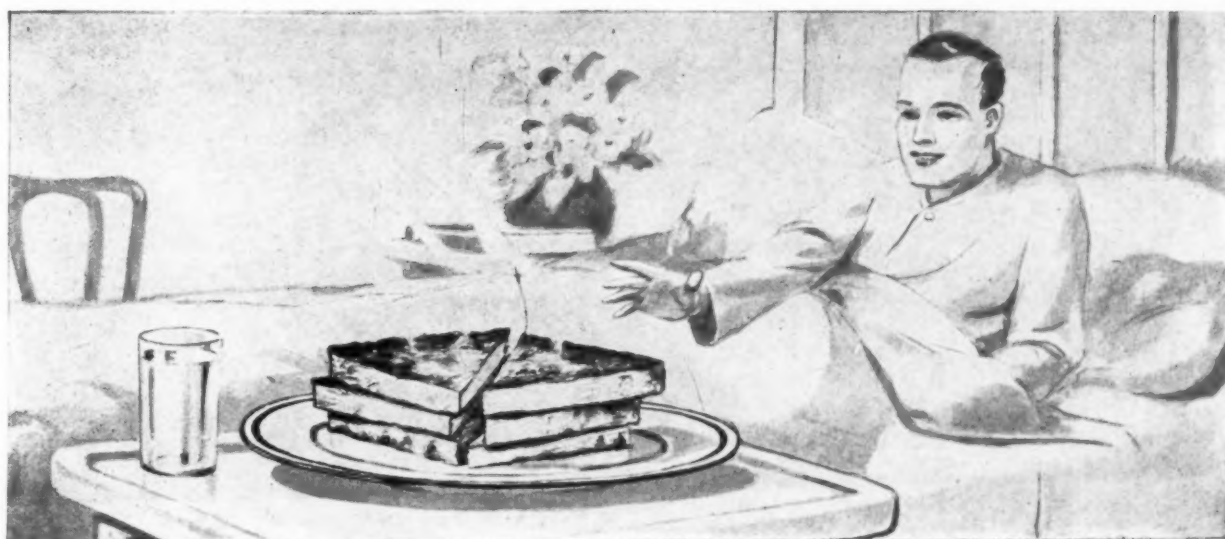
The chairman of the publication committee was presented by Dr. Helen MacMurchy with bound volumes of the *Canadian Nurse* for the first six years of the publication of the magazine. These volumes have been placed with the archives in the national office. Dr. MacMurchy was the editor of the magazine during the first six years of its existence.

### Health Departments Have Exhibits

The departments of health and of public health nursing in the provinces arranged several excellent exhibits. Exhibits were also placed by the Junior Red Cross of Canada, by the Victorian Order of Nurses, and by the training schools of several hospitals. The Macmillan Company, and the J. F. Hartz Co., Ltd., arranged booths for the exhibition of text books, charts, etc., and had representatives in attendance.

Automobiles were on hand at all hours for those who

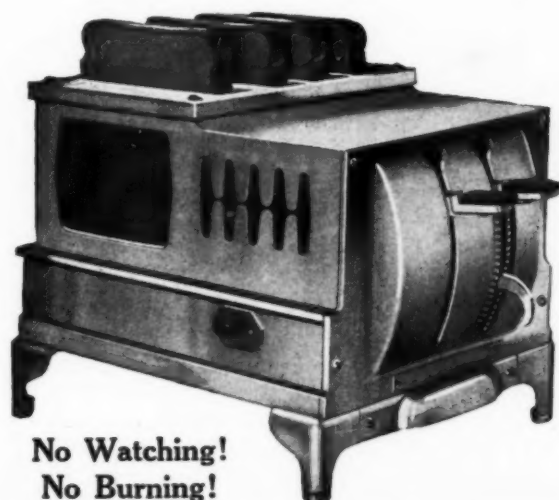




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could find time to visit the various hospitals, clinics, and health departments of the city. Drives were arranged wherever possible to allow the visitors to see some of the of the beauty for which Hamilton is noted.

The convention was adjourned at the close of the session on Wednesday afternoon, June 25. Many of those in attendance remained for the meeting of the Canadian Association of Nursing Education which lost its identity at the close of the final session on Friday, June 27 when that association automatically became the nursing education section of the Canadian Nurses' Association.

Officers elected for 1924-26 are: honorary president, Miss Mary Agnes Snively; president, Miss Jean E. Browne; first vice-president, Miss Kate Mathieson; second vice-president, Miss Mabel Hersey; honorary secretary, Miss Mabel F. Gray; honorary treasurer, Miss Mary Shaw, and executive secretary, Miss Jean S. Wilson, National Office, 609 Boyd Bldg., Winnipeg, Man.

#### Seventeenth Meeting of C. A. N. E.

The seventeenth meeting of the Canadian Association of Nursing Education was also held in Hamilton, June 25 to 27 in conjunction with the nurses' association of which it became a branch at this meeting. By a vote that was practically unanimous the association of nursing education merged with the newly christened Canadian Nurses' Association.

In her presidential address, Miss F. M. Shaw, director of the school for graduate nurses, McGill University, referred to the long and honorable history of the association and predicted greater opportunity for the organization's usefulness in the future as a part of the Canadian Nurses' Association.

Miss Grace Fairley, superintendent of nurses, Hamilton City Hospital, Hamilton, gave a summary of nursing progress in the foreign field. Miss C. Reimann, secretary of the International Council of nurses, Denmark, who was present, supplemented the address by a description of nursing conditions in Denmark. She brought out that in Denmark greater emphasis is laid upon the training of nurses in the care of mental patients. Students in Denmark are required to spend three months in this branch of training.

The second session of the convention was devoted to a consideration of the report presented by Miss M. F. Gray, supervisor of nursing housekeepers for the province of Saskatchewan, on the need for a subsidiary type of nursing service. The report revealed a wide divergence of opinion in different parts of the country as, for instance, in New Brunswick where women are trained as subsidiary nurses and in other provinces where this policy is depreciated and other policies advocated. Miss Gray was requested to retain the chairmanship of the committee of investigation the duty of which will be to submit a constructive policy for the consideration of the section at a subsequent meeting.

A round-table discussion was then held on the problems incidental to administration and teaching in schools of nursing.

#### Symposium on Public Health Nursing

The afternoon session was devoted to a symposium on the training school and public health nursing. The topic was introduced by Miss Moag, district superintendent, Victorian Order of Nurses, Montreal, Que., who spoke on "Every Nurse A Public Health Nurse." The problem was approached from different angles by Miss E. K. Russell, director of the department of public health, nursing, Uni-

versity of Toronto, Ont., and Miss E. Johns, assistant professor, department of nursing and health, University of British Columbia.

At the close of the session Miss M. Hersey, superintendent of nurses, Royal Victoria Hospital, Montreal, Que., presented a report of the experiment which is being conducted in group nursing in that institution.

At the evening session an address "Changing Aims in Nursing Education," was presented by Miss Isabel M. Stewart, associate professor, department of nursing and health, Columbia University, New York, N. Y. Miss Stewart showed the close relationship which should exist between nursing education and education in general and pointed out the broad horizon which is opening to the nursing profession.

The officers elected for the coming term are: Miss F. M. Shaw, president (re-elected); Miss Ethel Johns, vice-president, and Miss Ferguson, Alexandria Isolation Hospital, secretary.

One of the objectives of the new section is the assembling of material upon which a list of approved training schools for Canada may later be based.

#### CATHOLIC NURSES HOLD FIRST INTERNATIONAL CONFERENCE

The first international conference of Catholic nurses was held at Spring Bank, Okauchee, Wis., convention headquarters of the Catholic Hospital Association, June 21, 1924. The conference was attended by registered nurses from some twenty localities, eleven states being represented in addition to Canada and Ireland.

On the evening of June 21, a retreat was begun for graduate nurses conducted by the Rev. E. F. Garesché, S. J., general spiritual director of the International Catholic Guild of Nurses. Following the retreat, a series of organization meetings of the guild were held at which both the constitution and by-laws were discussed and amended.

After the adoption of the constitution and by-laws, an election was held to select the international officers. Miss Katherine McGovern, R.N., St. Mary's Hospital, Minneapolis, Minn., was elected president of the guild; Miss Loretta Mulherin, St. Joseph's Hospital, Denver, Colo., first vice-president; Miss Mary Sullivan, St. Luke's Hospital, Aberdeen, S. D., second vice-president; Miss Mary Dorais, St. John's Hospital, St. Louis, Mo., secretary; Miss Evelyn Shea, St. Francis Hospital, Blue Island, Ill., treasurer.

The purposes of the guild are to bring Catholic nurses together for their individual and professional welfare and to work for the interests of the nursing profession. An international headquarters was decided on and an annual convention will be held to promote the purposes of the guild.

Those who wish to join the guild are invited to send their dues with names and addresses to the International Catholic Guild of Nurses, Room 204, 610 Sycamore Street, Milwaukee, Wis.

This promises to be the healthiest year in the history of the country. In each thousand of population only half as many die in a year as was the rule fifty years ago. Medical skill is better equipped and better financed than ever before. Scientists are waging unrelenting war on the microscopic enemies of mankind. Reports of advances in knowledge of disease and in the technic of cure and prevention fill the press and medical journals.—*New York World*.



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*From the HOTEL MONTHLY, May, 1924*

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## REPRESENTATIVES OF N. Y. CONVALESCENT HOMES MEET TO STUDY SURVEY RESULTS

**F**OLLOWING the publication of the report of the study of convalescent facilities of New York, N. Y., the Public Health Committee of the New York Academy of Medicine called a conference in New York City, May 21, 1924, at which many of the larger convalescent homes and of the social service agencies were represented. Dr. Charles Loomis Dana, chairman, Public Health Committee, stated the purpose of the conference and called on Dr. E. H. Lewinski-Corwin to state the principal conclusions of the study. These he summarized as follows:

### Summary of Study

(1) There is at present no clear-cut definition of a convalescent home. Some of the institutions merge on one side with the fresh air homes, so-called, and on the other with the home for the chronics.

(2) Seven institutions are operated by hospitals; the remaining sixty-two homes listed as providing care for convalescent patients are operated independently of hospitals. They are intended to serve the needs of the community rather than those of individual hospitals.

(3) The total number of beds in institutions figured on a year-round basis is in the neighborhood of 2,600. Numerically, the facilities are sufficient to meet the needs of the community, judging by the pragmatic standard formulated by Dr. Frederic Brush and others.

(4) Owing to the fact, however, that on the whole not more than seventy-five per cent of the available bed capacity is utilized, the needs of the community are not fully met. The reason for the under utilization can be briefly listed as due to the refusal on the part of homes to take certain types of cases, the patients' preference of one institution to another, the failure of patients to report after they have been admitted, the lack of funds to enable some of the institutions to operate to full capacity, the requirements of some of the homes that the patients undergo medical and social investigations before admission, the lack of synchronization of the discharge of the patients from the hospital with the admission to the convalescent homes, and finally the lack of a central information service regarding existing facilities.

(5) Of all agencies dealing with the sick, the convalescent homes suffer most from the lack of generally accepted standards of administrative and medical procedure. The problem of convalescence has been a neglected phase of medicine. There has been no serious discussion of the kind of care which the various types of convalescent patients require. There has likewise been no thorough consideration of the types of cases which should be cared for jointly, and which would harmonize from an administrative and medical point of view.

(6) The whole problem of convalescence in this country seems to be in a magmatic stage; it has not become crystalized in thought and procedure. The workers in the field rarely come together to discuss their common problems. Very few of them know institutions other than their own or are familiar with the type of care afforded to patients elsewhere. Of the 375,000 cases passing through the hospitals in New York City annually, about 200,000 are surgical. It would seem, therefore that the after-care of surgical patients is

one of the outstanding community problems.

Dr. Brush brought out the principal conditions which are as yet not met by existing facilities. He spoke of the particular contributions which America has made in the treatment of convalescent patients and also of the great opportunities in disease prevention and character building. He mentioned the need for convalescent provisions for the preventable and border-line neuro-mental cases, the non-tuberculous pulmonary cases, the preventable heart disease cases, the special diet cases, as well as provisions for those who are seriously crippled, adolescent boys, certain types of male adults, and those suffering from rheumatism and arthritis; also for the people of the colored race, in general. Dr. Brush also emphasized the importance of proper follow-up service and re-employment. He pointed out the need of an association of convalescent homes which would deal with the problems of admission, standards of care, finance, legal liability, and such other problems as concern all of them. He stressed the fact that such an association would be able to increase the use of beds in winter convalescence and would better the average utilization of all the facilities and help to dominate waste in effort and money; it would also stimulate gifts for convalescent work and research in the sub-standard health conditions.

Dr. George David Stewart, president, Academy of Medicine and chairman of the committee in charge of the Hospital Information Bureau, spoke of the desirability of a closer co-operation between medical men and social service workers in hospitals in connection with the placement of patients requiring institutional convalescence. He emphasized the general consensus of opinion prevailing at the meeting for a better co-ordination of existing facilities and of a continuous joint study of the needs of the community. He pointed out the value to all concerned of a central office where information about vacancies for the placement of convalescent patients in all the homes would be readily available. He stated that the Hospital Information Bureau is ready to assist in this work and offered the facilities of the academy for meetings and conferences pertaining to the problems.

### Committee to Work Out Problem

At the close of the meeting Dr. Stewart offered the following resolution which was unanimously adopted: "Resolved that those present at the conference called by the Public Health Committee on May 21, 1924, urge:

That the Public Health Committee of the New York Academy of Medicine, the Hospital Information Bureau, and the Sturgis Research Fund proceed respectively,

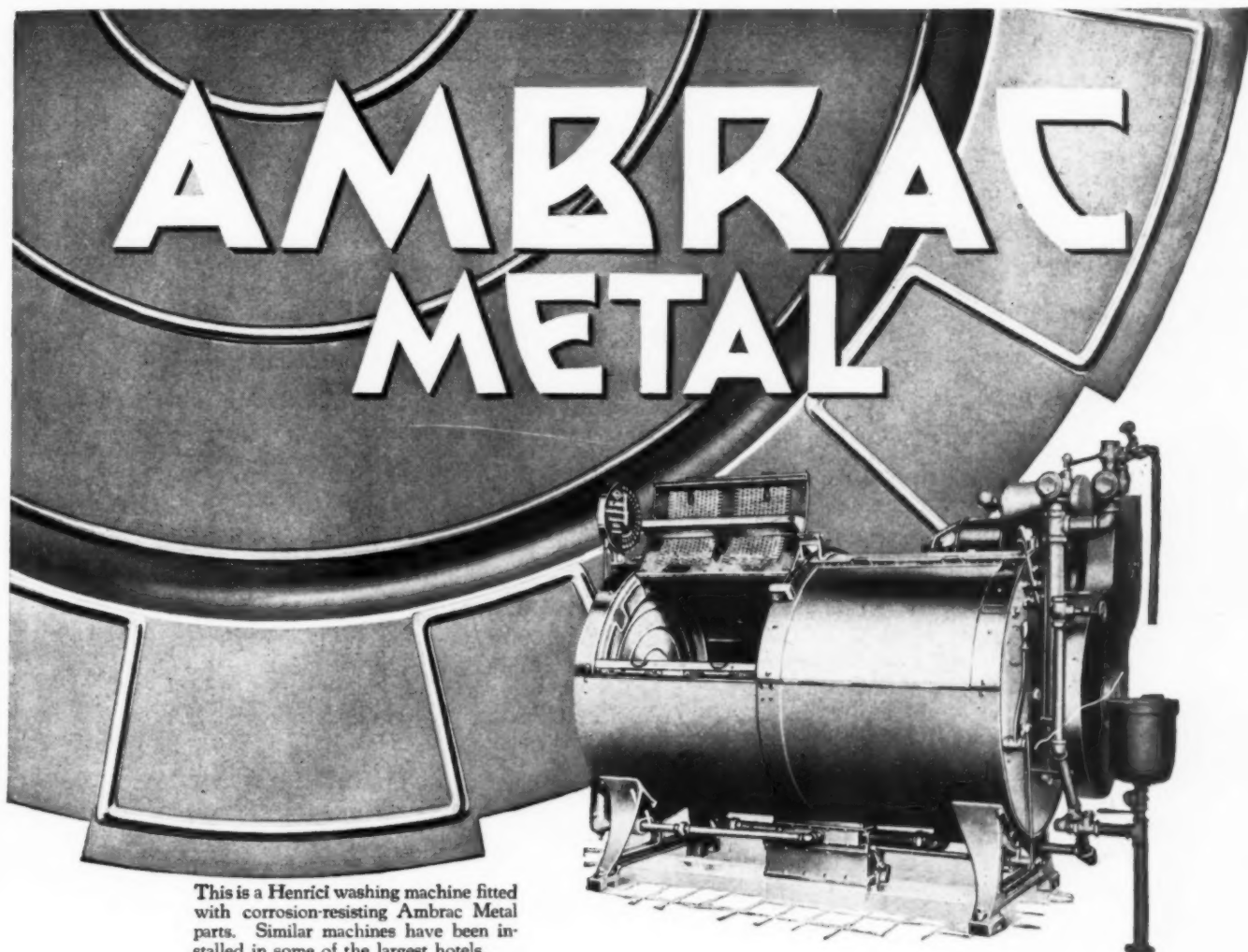
First, to study the convalescent needs of the City and to formulate a community policy to be submitted for discussion at a subsequent meeting, in which representatives of all the convalescent homes be invited to participate;

Second, to develop medical and administrative standards for the guidance of the convalescent homes; and

Third, to organize a central reference bureau as well as a central statistical office."

The Public Health Committee has accepted the responsibility placed upon it by the conference and has accordingly appointed four sub-committees to formulate standards for medical, surgical, pediatric and neurological cases.





This is a Henrici washing machine fitted with corrosion-resisting Ambrac Metal parts. Similar machines have been installed in some of the largest hotels.

## Spotless Linen— Continuous Laundry Service

**S**POTLESS LINEN is not so much a matter of laundry solution in these days of standardized washing methods, as of metal.

If the cylinders and shells of the laundry machines are of corrodible metal there are bound to be unsightly stains which must be removed at an additional cost. Also eventual stoppage of a necessary machine for costly repairs. Crippled service at a critical time.

Ambrac Metal (white clear through) has been developed after years of experimentation by The American Brass Company, and overcomes all these difficulties.

It cannot stain fabrics, for this metal successfully resists the corrosive action of all laundry solutions. Slow to tarnish and easy to clean, Ambrac will outlast any metal yet developed for the severe conditions of washing machine service.



**THE AMERICAN BRASS COMPANY**  
General Offices: Waterbury, Conn.

## BOOK REVIEWS AND CURRENT HOSPITAL LITERATURE

### THE SCIENCE AND ART OF ANESTHESIA

By Col. William Webster, M. D., C. M., D. S. O., Professor of Anesthesiology, University of Manitoba Medical School; Chief Anesthetists, Winnipeg General Hospital; Pathologist, Winnipeg General Hospital, Winnipeg, Man.<sup>1</sup>

Colonel Webster is all too modest in concluding that his book is merely an effort to place before the medical student and the physician in general practice a small manual on the subject of anesthesia. Dr. Webster has had an unusual experience, not only in teaching some of the basic sciences, but also in the technical administration of anesthetics as a specialist, and his book reflects his capacity along both lines.

His chapter on the pharmacophysiology of anesthesia is a concise resumé of the best thought on the subject and the latest developments. This matter has been approached with the idea of making the chemical properties as well as the special pharmacophysiology of the individual anesthetics known and understood.

In dealing with the use of the routine anesthetics Dr. Webster is judicious in explaining in detail those methods of administration which have served him best and he does not hesitate to describe the types of apparatus that are perfecting adjuncts. Some surgeons and hospitals are under the misapprehension that anesthesia is becoming cluttered up with mechanical devices, but the specialist, in explaining their scope and utility, readily shows their application to the physiological era of anesthesia. This is especially true of nitrous oxid and other forms of gas anesthesia.

Ether is considered in all the standard methods of administration and also in the different sequences and combinations which are commonly associated with its use.

Nitrous oxid is given the importance it deserves, and its physiology as well as technical administration are well covered. While the chapter on ethylene is brief, practically all that is written about nitrous oxid holds good for the newer anesthetic.

Out of a broad clinical experience Dr. Webster gives very valuable advice regarding selection of the anesthetic in relation to the nature of the operation and the condition of the patient. He considers the value of heating anesthetic gases as well as the advantages of preliminary medication. The effects of temperature and humidity, surgical shock, post-anesthetic acidosis and other complicating factors come in for due consideration in the pre-operative and post-operative care, nor is the patient viewpoint neglected.

Spinal, local, regional and intravenous anesthesia are very briefly considered.

<sup>1</sup>C. V. Mosby Co., St. Louis, Mo., 1924.

Dr. Webster has a splendid vision of the future of the science and art of anesthesia and he does not hesitate to emphasize the need and value of case records as well as collated statistics. He is also convinced that the medico-legal responsibilities of anesthesia are entirely professional in character.—F. H. M.

### FOOD, HEALTH AND GROWTH

By L. Emmett Holt, M. D., Sc. D. LL. D., formerly Professor of Diseases of Children, College of Physicians and Surgeons, Columbia University, Physician-in-chief, Babies' Hospital, New York, N. Y., 1922.<sup>2</sup>

With the crystal clearness and simplicity that has marked his every written word. Dr. Holt had gathered together the latest fundamental facts on food, health and growth into one volume.

It is difficult for one who has sat at his feet to review the book and not think of the man. A great clinician, a true scientist, an incomparable teacher wedded inviolably to the idea that a nation's greatness is not measured by its standing army or its tonnage at sea so much as by its interest in child life. We know now that we will not soon look on his like again.

This volume contains substantially the Lane Lectures which Dr. Holt gave at Leland Stanford Junior University in San Francisco. Every important interrelationship of nutrition, resistance to disease, physical growth and mental development is presented from angles that cannot fail to be stimulating.

The chapter on the accessory food factors is the simplest, yet most informative presentation of this newly developed field which one can possibly imagine. The wheat is thoroughly separated from the chaff by a painstaking analysis of the laboratory results as applied to the actual nutritional problems of the growing organism.

Dr. Holt was constantly seeking means for solving health problems. In his chapter on health education this is brought out strikingly by his everyday illustrations of just what educators must do to instill in the child mind the rules of the game of health.

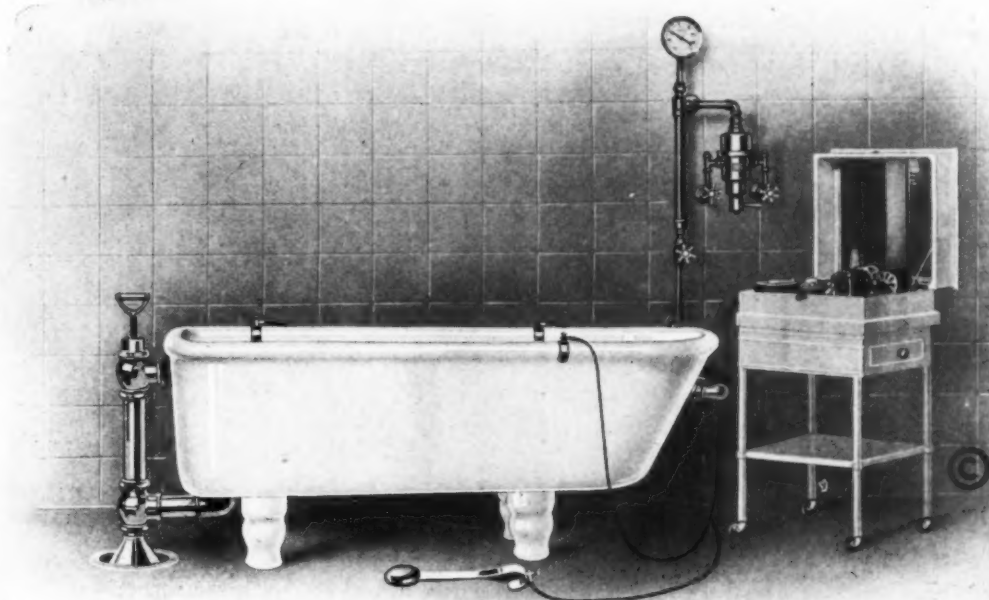
Foods are being revalued. The old standards by which they were gauged are by no means discarded, but to understand the changes which have followed the widespread laboratory investigations, one can not do better than read this last volume of America's greatest pediatrician, L. Emmett Holt.—L. C. S.

### NATIONAL HEALTH SERIES

Volumes eleven, twelve, thirteen and fourteen of the twenty-volume National Health Service Series have been distributed. These volumes are entitled "Love and Mar-

<sup>2</sup>The Macmillan Company, 1923.





## Combination Continuous Flowing and Electric Bath

THE illustration shows a new Clow development which forms in one unit a combination bath by means of which patients may receive, in addition to a prolonged bath treatment, the application of low tension electrical modalities, including various forms of galvanic and sinusoidal currents.

This equipment is especially designed to meet the requirements of general hospitals having no complete hydro and electro-therapeutic departments.

The tub is of solid porcelain, 6½ feet long, and is provided with hammock and cover. The control apparatus supplying the water is of the thermostatic type, insuring against scalding and providing water of constant temperature, which may be easily observed from the dial thermometer.

The electrical apparatus is of the very best and latest design, and being mounted on a portable stand, may be used at any other desired locality wherever a plug connection is available.

**JAMES B. CLOW & SONS**

GENERAL OFFICES

534-546 SOUTH FRANKLIN STREET, CHICAGO

*Sales Offices, in the Principal Cities*

# CLOW

When using advertisements see Classified Index, also refer to YEAR BOOK.

riage," "The Expectant Mother," "Tuberculosis," and "Venereal Diseases."

The volume on love and marriage is written by Dr. Thomas W. Galloway, former professor of zoology, Beloit College, Beloit, Wis., and associate director, department of educational measures, American Social Hygiene Association, who presents the subject in an enlightening manner devoid of the technical terms which usually obscure the meaning of such treatises to the average reader.

The volume entitled "The Expectant Mother," is presented by Dr. Robert L. DeNormandie, instructor in obstetrics, Harvard Medical School, a recognized authority on this subject. The volume gives specific directions for the care of the mother's health presented in a practical way.

The volume on Tuberculosis is written by Dr. Linsly R. Williams, managing director, National Tuberculosis Association, and author of one of the most widely known large treatises on tuberculosis. The volume is considered to be the best brief statement of the nature, treatment and prevention of tuberculosis which has ever been written for laymen.

The volume on venereal diseases is written by Dr. William F. Snow, general director, American Social Hygiene Association, who skillfully handles the subject in the interest of the individual and general public.

#### NUTRITION: THE CHEMISTRY OF LIFE

By Lafayette B. Mendel, Sterling Professor of Physiological Chemistry, Yale University, New Haven, Conn.<sup>1</sup>

"Anything which Dr. Mendel has to say on nutrition is always of interest, and the publication of this volume makes it possible for all of us to have the benefit of his course of lectures given at the University of California under the Hitchcock Foundation. This course was given under the title, "Viewpoints in Study of Nutrition," and the author states that, "They represent merely an effort to indicate some of the more recent contributions to the science of nutrition and also some problems which await further study." The subjects are:

- I. The Science of Nutrition: A Retrospect.
- II. The Importance of "Little Things" in Nutrition.
- III. The Vitamines.
- IV. The Protein Factor in Nutrition.
- V. The Energy Problem in Nutrition.

In the retrospect the author shows that attention has been given to nutrition and similar subjects from the time of Hippocrates (460-370 B. C.). He then follows experimental progress up to 1923 A. D. The other lectures are up-to-date live discussions of the subjects as mentioned above. The author tells us that in determining what constitutes a food chemical analysis of the substance is necessary but not all sufficient, its physiological effect on man or animals must also be known.

A quarter of a century ago the construction of a "balanced ration" seemed a simple matter theoretically, but with continued study and careful investigation many elements have been discovered, which have an important relation to nutrition so that dietetics as considered today is not simple; neither is it chiefly theoretical, but, on the contrary, decidedly practical.

The inorganic food elements and vitamins are discussed in detail, and contributions of leading investigators summarized. Thus we have dependable data on the value in the dietary of calcium including comparison of vegetable and milk as sources of calcium; iron, relating Bauman's discovery of iodine as an essential constituent of the

thyroid gland, and subsequent experiments in the use of iodine both for its therapeutic effects and as a preventive measure; the importance of phosphorus in the diet, and other "little things" which are essential. The lecture on vitamin tells of the progress made in the knowledge of these factors and their relation to life and growth so far as is at present known. Medical men not specializing in this subject yet wanting this information will be grateful for the chapter on the protein factor.

The student in dietetics and dietotherapy will find this book scientific and accurate, as Dr. Mendel's work always is, yet it is remarkably free from technical terms.

There are numerous excellent illustrations and charts which add much to the value of the book.—L. G. G.

#### COMMUNITY DENTAL SERVICE IN NEW YORK CITY

By Michael M. Davis, Jr., Committee on Dispensary Development, United Hospital Fund of New York, and Clare Terwilliger, R.N., New York, N. Y.

**I**N this report the present clinical facilities for dental service in New York City are described, and a comprehensive plan is outlined for preventive dentistry as part of a general health program.

The survey on which the report was based covered 104 dental clinics, of which fifty-one were located in hospitals, unattached dispensaries and dental colleges, and fifty-three were in non-medical institutions such as health centers, settlements, churches and family welfare agencies.

The general findings indicated that facilities for dental service are at present entirely inadequate for the estimated needs. Quantitative limitations of service were discovered in the number of clinics and available personnel, in the types of treatment available, and in the clientele accepted. Thus:

(1) There are altogether only 5,000 registered dentists, whereas 12,000 are needed if the whole population is to be adequately served. This estimate is based on the calculation that the average working time of a dentist is 2,000 hours annually, and that each individual requires four hours, thus allowing 500 cases per dentist.

Oral hygienists to do surface cleansings, and give instruction, are likewise far too few; there having been only 1,000 graduated in all the schools of the country so far.

(2) The second limitation is due to the fact that the services rendered by the clinics vary greatly, some being restricted to extractions or emergency relief of pain, and others offering a complete program of prophylaxis, surgery, fillings, root canal work, plates and orthodontia. Only five clinics offered this full program, and eight additional did all but plates or orthodontia.

(3) The third restriction to use of the clinics as community resources is that more than half are open only to a special clientele, as the patients in the wards or outpatient departments of hospitals, the children of a school or even of a grade, or the members of a congregation. Thus, there are only forty-seven clinics of the 104 studied, which may be used by anyone applying for the particular service rendered.

When the character of service rendered was analyzed it was found that in general there was too little correlation of dental with other medical treatment, and that the work was almost entirely of a curative or remedial nature, with little provision for preventive dentistry.

<sup>1</sup>Yale University Press, New Haven, Conn., 1923.



# Physicians and Surgeons

**Pituitary Liquid (Armour)**, a pure solution of Posterior Pituitary active principle standardized physiologically (no preservative) oxytocic, stimulant in uterine inertia, peristaltic paralysis, shock, collapse, 1 c. c. ampoules surgical,  $\frac{1}{2}$  c. c. ampoules obstetrical.

**Sterile Catgut Ligatures**, Plain, Chromic, Iodized. Strong, smooth, supple; made from lambs' intestines selected in our abattoirs for surgical purposes. Nothing better can be manufactured from catgut. 000 to number 4—60 inch lengths.

**Suprarenalin Solution**, 1:1000. Astringent and hemostatic. A stable, water white, non-irritating preparation of the astringent, hemostatic and pressor principle of Suprarenal Substance. (Being free from chemical preservatives, Suprarenalin Solution is the ideal product for e. e. n and t work.)

## THYROIDS

Powder 1/10, 1/4, 1/2,  
1 and 2 grain tablets

## CORPUS LUTEUM

Powder 2 and 5 grain  
capsules  
2 and 5 grain tablets

## PARATHYROIDS

Powder & 1/20  
1/10 grain tablets

*Booklet on the Endocrines for Medical Men*



**ARMOUR AND COMPANY**  
CHICAGO

## NEWS OF THE HOSPITALS AND SANATORIUMS

*The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.*

### General

**Seven Veteran's Bureau Hospitals Completed.**—Seven new tuberculosis and neuro-psychiatric hospitals are ready for opening and four more hospitals and many new additions are in the course of construction. The seven hospitals just completed are: Chillicothe, Ohio; a 452-bed neuro-psychiatric hospital built by the war department; Knoxville, Iowa, a 456-bed neuro-psychiatric addition constructed by the war department; Northampton, Mass., a 462-bed neuro-psychiatric hospital built by the navy; Tupper Lake, N. Y., a 358-bed tuberculosis hospital built by the navy; Northampton, Mass., a forty-five bed neuro-psychiatric hospital built by the war department; Chelsea, N. Y., a 400-bed tuberculosis hospital, built by the supervising architects of the treasury; Little Rock, Ark., a 203-bed addition for neuro-psychiatric patients, built by the Veterans' Bureau.

With the completion of the following institutions, more than 1300 additional beds will be made available for sick veterans: Camp Custer, Mich., a 527-bed neuro-psychiatric hospital, completion estimated August 15; St. Cloud, Minn., a 262-bed neuro-psychiatric, completion estimated August 15; Livermore, Cal., a 268-bed tuberculosis hospital, which calls for completion March 15, 1925.

**Hospitals and Additions Recently Opened.**—The following hospitals and additions have recently been opened: A new home for the Old People's Home, Hempstead, N. Y.; a new home for the Jamaica Hospital, Jamaica, N. Y.; Mary B. Smith Sanitarium, Ashville, N. C.; Lincoln Hospital, Durham, N. C.; a new addition to the Lawrence Hospital, Winston-Salem, N. C.; a new home for the children's Hospital, Columbus, Ohio; a new cottage for the Institution for Feeble-minded, Columbus, Ohio; a new building for the Methodist Children's Home, Worthington, Ohio; a new addition for the Bethesda Hospital, Zanesville, Ohio; the new building for the Lock Haven Hospital, Lock Haven, Pa.; the new nurses' home for the Methodist Episcopal Hospital, Philadelphia, Pa.; Northern Liberties Hospital, Philadelphia, Pa.; Orleans County Memorial Hospital, Newport, Vt.; a new wing for St. Joseph's Hospital, Buckhannon, W. Va.; a new addition to the Holy Family Hospital, Manitowoc, Wis.; Eastern Star Hospital, Dousman, Wis.

**Requests and Donations.**—The following hospitals and

allied institutions have been named recipients of gifts and donations: The Roosevelt Hospital, St. Luke's Hospital and the New York Hospital, New York, N. Y., each \$100,000, and the Woman's Hospital, New York Eye and Ear Infirmary for Women, and the Orthopedic Dispensary, each \$25,000 by the will of the late Miss Emily F. Southmayd; the Presbyterian Hospital, New York, N. Y., \$100,000, and the Hospital for the Ruptured and the Northern Westchester Hospital each \$10,000 by the will of the late William Sloane; the Abington Hospital, Philadelphia, for the maintenance of free beds in memory of her parents, grandparents and brother, \$10,500, by the will of the late Mrs. Mathilda K. Millick; St. Mary's Hospital and Blessing Hospital, Quincy, Ill., each \$2,500 by the will of Hannah Heyman, New York, N. Y.; the Peoples Hospital, New York, N. Y., and the New York Hospital, each \$1,000; the Denver Sanatorium of the Jewish Relief Society \$500 by the will of Max Davidson; Wyckoff Heights, Bushwick, St. Catherine's and the Bethany Deaconess Hospitals, Brooklyn, N. Y., each \$500 by the will of John Auer.

### Alabama

**Children's Hospital Opens.**—The Children's Hospital, Birmingham, was recently opened.

**Negro Control Established at Tuskegee Hospital.**—All negro control has been established at the Tuskegee Alabama Veterans' Bureau Hospital, Tuskegee, thus ending a long controversy involving this issue. Dr. Joseph H. Ward, Indianapolis, Ind., formerly chief of surgical service, has been appointed chief medical officer and commandant.

### California

**To Superintend Yolo County Hospital.**—Mr. Fred Lamb has been appointed new superintendent of Yolo County Hospital, Woodland.

**French Hospital to be Enlarged.**—A three-story addition is being planned for the new French Hospital, San Francisco, which will be erected at a cost of \$90,000.

**La Jolla Hospital Opens.**—The new four-story La Jolla Hospital, San Diego, was opened July 5. The new hospital contains thirty-one private rooms and wards besides four operating rooms and solariums.

**New Metabolic Clinic for San Diego.**—A new metabolic clinic is now nearly completed at San Diego. It includes a hospital of fifteen beds and a complete laboratory. Dr. James W. Sherrill, formerly associated at the psychiatric clinic, Morristown, N. J., has been appointed medical director.

**Plan Isabelle J. Norris Hospital.**—Plans have been drawn for the proposed Isabelle J. Norris Memorial Hospital, Los Angeles, which is to contain 325 beds, twenty-



## WORLD WIDE SERVICE

Our first campaign for the American Hospital in Paris in June of last year produced such fine results, \$400,000, that our Mr. Keen was asked to return to Paris for a second campaign this year. The authorities of the Hospital hoped for \$100,000 as a result of this campaign though they needed much more.

The amount secured in this second campaign for the same object and chiefly among the same people, was \$260,000, making a total of \$660,000, a splendid showing for the little colony of Americans in Paris.

Mr. Keen is now in Dublin conducting a campaign for the Sir Patrick Dun Hospital of that city, with a prospect of much other European business.

We also have calls from China and other parts of the world.

### The following hospitals, among others, have profited by our service:

	Objective	Secured
Fifth Avenue Hospital, New York City.....	\$2,000,000	\$1,850,000
Post Graduate Hospital, New York City.....	2,000,000	1,600,000
United Hospital, Rochester, N. Y.....	1,300,000	1,395,000
Union Protestant Infirmary, Baltimore, Md.....	750,000	810,000
Church Home and Infirmary, Baltimore, Md.....	600,000	450,000
Washington Hospital, Washington, Pa.....	500,000	518,000
Miami Valley Hospital, Dayton, Ohio.....	500,000	515,000
Methodist Hospital, Fort Worth, Texas.....	500,000	502,512
Stanford University Hospital, San Francisco.....	500,000	500,000
Presbyterian Hospital, Denver, Colo.....	500,000	500,000
Maryland General Hospital, Baltimore.....	450,000	483,000
Paterson General Hospital, Paterson, N. J.....	400,000	450,000
Memorial Hospital, Pawtucket, R. I.....	300,000	422,190
American Hospital of Paris, France.....	400,000	660,000
Eliza Jennings Home, Cleveland, Ohio.....	300,000	362,056
Children's Hospital, St. Louis, Mo.....	300,000	330,000
Mercy Hospital, Pittsfield, Mass.....	250,000	328,000
University of Maryland Hospital, Baltimore.....	250,000	250,000
St. Mary's Hospital, Rochester, N. Y.....	225,000	344,890
Southside Hospital, Bayshore, Long Island, N. Y.....	200,000	230,000
Toronto Western Hospital, Canada.....	200,000	210,000
White Plains Hospital, White Plains, N. Y.....	200,000	200,000
St. Lawrence Hospital, Lansing, Mich.....	200,000	206,000
Maternity & Children's Hospital, Toledo, Ohio.....	150,000	152,500
Methodist Hospital, Sioux City, Iowa.....	125,000	153,500
Pottsville Hospital, Pottsville, Pa.....	100,000	120,000
Haystack Hospital, Mayaville, Ky.....	100,000	116,800
Saratoga Hospital, Saratoga Springs, N. Y.....	100,000	116,000
Cape Cod Hospital, Hyannis, Mass.....	75,000	110,000
Ogdensburg City Hospital and Orphanage, N. Y.....	75,000	123,369
United Helpers Home, Ogdensburg, N. Y.....	75,000	116,000
Dobbs Ferry Hospital, Dobbs Ferry, N. Y.....	75,000	116,019
Vineland Hospital, Vineland, N. J.....	75,000	76,000
Shenandoah Hospital, Shenandoah, Pa.....	70,000	110,000
St. Francis Hospital, Poughkeepsie, N. Y.....	75,000	100,000
St. Francis Hospital, Port Jervis, N. Y.....	75,000	80,000
Newcomb Hospital, Vineland, N. J.....	50,000	60,000

In the Last FIVE YEARS

# \$359,306,870

HAS BEEN SECURED UNDER OUR DIRECTION

Our Quarterly Bulletin FINANCING SOCIAL PROGRESS gives further details and will be sent upon request.

WE ARE THE PIONEERS IN THIS FIELD

MAY WE SERVE YOUR HOSPITAL?

**WARD, WELLS, DRESHMAN & GATES**  
 PHILANTHROPIC ORGANIZATION AND FINANCE  
 NEW YORK - METROPOLITAN TOWER - CHICAGO - WRIGLEY BLDG

When using advertisements see Classified Index, also refer to YEAR BOOK.

# RODDIS DOORS



**SAGINAW GENERAL HOSPITAL**

Saginaw, Michigan

Architects: Richard E. Schmidt, Garden & Martin, Chicago, Ill.  
Contractors: W. W. Jenkins Co., Chicago, Ill. and Saginaw, Mich.

**S**AGINAW'S newest hospital has made positive that its doors will remain sanitary, sound-proof, fire-resisting and beautiful of appearance for so long as the building stands, by installing Roddis Flush Doors throughout. This capacity for endless service, this lasting durability, is due to the exclusive Roddis design—5-ply construction; top, bottom and sides securely sealed to keep out moisture; the entire Door forever cemented together by waterproof glue.

This inbuilt quality forbids the Doors to sag, warp, shrink, swell, separate, or check. Yet, these features are not visible even to the expert eye; they are not detected by any external evidence. They are built into the Doors, made an integral part of them, by the maker. The only assurance of so complete merit is the name and reputation of the maker.

That is why more Roddis Flush Doors are being installed in hospitals than any other. Their unfailing ability to deliver continuous service of unapproachable degree is the reason for the unqualified guarantee that can be, and is, given with every Door.

Our 78-page catalog will gladly be mailed upon your request.

## RODDIS LUMBER & VENEER COMPANY

Marshfield, Wisconsin

Branches in all principal cities throughout the world

For a Quarter-Century, the World's Largest Makers of  
Flush and French Doors

five of which will be free. It will be operated by a staff of 100 physicians. In addition to the 325 general beds, it is planned to have fifty maternity rooms, eight operating rooms, and a nurses' home to house 150 to be erected in conjunction with the main hospital building.

### Colorado

**Dr. Tillotson Made Head of Hospital.**—Dr. Demetrius Tillotson, Indianapolis, Ind., has been appointed superintendent of the new Presbyterian Hospital, which is in course of construction, Denver, Colo.

### Connecticut

**To Superintend Charlotte Hungerford Hospital.**—Miss Louise McLeod, Montreal, Que., has been appointed superintendent, Charlotte Hungerford Hospital, Waterbury, to succeed Col. Thomas Dugan who has been acting superintendent since Miss Margaret Ruud resigned several months ago.

### District of Columbia

**New Additions to Gallinger Hospital Completed.**—The new additions to the Gallinger Municipal Hospital, Washington, were dedicated recently. The new buildings contain a total capacity of 200 beds and are two stories high.

**Red Cross Building for Walter Reed Hospital.**—The executive committee of the American Red Cross has approved the erection of a permanent recreation building for the use of convalescent soldiers at the Walter Reed Hospital, Washington, D. C.

### Florida

**Edward-Maxwell Hospital to Have Ten-Bed Addition.**—Work is now progressing on the ten-bed addition to the Edward-Maxwell Hospital, Ft. Lauderdale.

### Illinois

**New Nurses' Home for Grant Hospital.**—A new nurses' home is to be erected at Grant Hospital, Chicago.

**Mount Sinai Hospital to Have New Home.**—Mount Sinai Hospital, Chicago, is planning on having a new seventy-five bed building.

**Nurses Home for Keystone Hospital.**—Bids have been taken for the erection of a \$15,000 nurses' home for the Keystone Hospital, Chicago.

**Two New Buildings for Englewood Hospital.**—Two new buildings to contain 100 beds are to be erected at the Englewood Hospital, Chicago.

**Dr. Cobb to Superintend Iroquois Hospital.**—Dr. Ralph B. Cobb has been appointed superintendent of the Iroquois Memorial Hospital, Chicago.

**New Hospital for Chicago Heights.**—Work has begun on the construction of a new hospital at Chicago Heights, which is to have a capacity of 185 beds.

**Plan County Tuberculosis Hospital.**—The St. Clair County Tuberculosis Society has started a movement to establish a county tuberculosis hospital.

**New Home for Garfield Park Hospital.**—Plans are being prepared for a new home for the Garfield Park Hospital, Chicago, to contain 200 private rooms.

**Approve Plans for County Tuberculosis Hospital.**—The Will County supervisors have approved plans for a county tuberculosis hospital that will cost \$125,000.

**Plan Addition to Swedish Covenant Hospital and Home of Mercy.**—A new seventy-five bed addition is being planned for the Swedish Covenant Hospital, Chicago.

**New Home for Highland Hospital.**—The cornerstone





*View at the left fails to do justice to the wide expanse of lawn and the magnificent shade trees on the property.*



*Smaller view shows the house from the rear, with a corner of the garage to the right, and includes the sunken Italian garden with tennis court at the left.*

## This Property Is Offered to an Acceptable Medical Organization for a Private Sanitarium

Located on a high, wooded point of the backbone ridge of Long Island, this remarkably beautiful property affords fine air and climate, widespread views and country privacy, although actually in the geographical center of New York City.

Mr. F. D. Asche, who was Vice-President of the Standard Oil Company of New Jersey, selected this site and built his Estate-Home, with a very great personal pride in the quality of workmanship and material and details of landscaping. It was finished only a short time before his death this year.

The property represents an investment of over \$125,000, spent with intelligence and without extravagance, and is ideally fitted

for a private sanitarium with clinical facilities.

There are 16 rooms and 4 baths; location of plumbing lines makes possible further lavatories, etc., at small expense. The grounds include about 5 acres of lawn, kitchen garden, tennis court and a sunken Italian garden, with a surrounding fringe of woods.

There is a 5-car garage with extension and living quarters above, plumbing and heating; easily convertible into a 7-room cottage or separate ward.

This property is offered to an acceptable medical organization at a fraction of its actual cost and on exceedingly liberal terms.

# Edgeworth Smith

AGENTS REPRESENTING THE ESTATE  
216 WEST 34TH STREET, NEW YORK  
482 HILLSIDE AVENUE, JAMAICA



When using advertisements see Classified Index, also refer to YEAR BOOK.

Look for this shield on all Sheets and Pillow Cases



Reg. U. S. Pat. Off.

### Grandmother's Dower Chest

**G**REAT-GRANDMOTHER began to hem Pequot Sheets and Pillow Cases for her dower chest when she was a very little girl. One by one they were put away in sweet-smelling lavender to become among her most treasured possessions when she married.

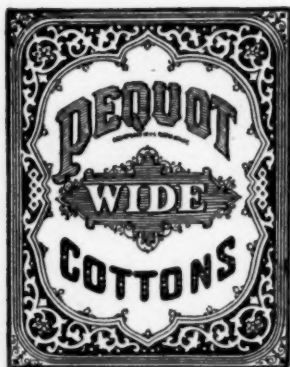
The same finish, the same delightful softness, the same number of threads are in the Pequot Sheets and Pillow Cases which her granddaughters buy ready-made today. Of uniform excellence for four generations, they continue to be the choice of the wise housewife and of the better hotels and hospitals.

Pequot Sheets and Pillow Cases are always to be identified by the well-known Pequot Shield. They are sold by most good dealers. They are attractively priced.

Pequot Sheeting and Pillow Tubing may be purchased by the yard, and can always be identified by the ticket reproduced below.

Made by Naumkeag Steam Cotton Company  
Salem, Massachusetts

Parker, Wilder & Company, Selling Agents  
Boston and New York



This label on all piece goods

was recently laid for the new home for the Highland Hospital, Belvidere. It is to be a one story building to contain forty beds.

**New Hospital for La Grange.**—Ground has been broken in La Grange for the erection of the new \$400,000 hospital building that will replace the La Grange Sanatorium, recently destroyed by fire.

**Will County Tuberculosis Sanitarium Planned.**—Contract has been awarded for a new home for Will County Tuberculosis Sanitarium, Joliet. It is expected to have the building completed by July 1925.

**Addition to Michael Reese Hospital Planned.**—Sketches are being prepared for the new addition to the Michael Reese Hospital, Chicago. The addition is to include a 100-bed private patients' pavilion and an operating pavilion.

#### Indiana

**First Unit to Be Dedicated October 7.**—Official announcement has been made that the first unit of the James Whitcomb Riley Memorial Hospital for Children, Indianapolis, will be dedicated October 7.

#### Iowa

**New Addition for Burlington Hospital.**—Bids have been taken for the erection of a new addition to the Burlington Hospital, Burlington.

**Hospital for Odd Fellows Home.**—The cornerstone of the new hospital for the Odd Fellows Home, Cedar Rapids, was laid recently.

**Ground Broken for New University Hospital.**—Ground has been broken for the erection of the first unit of the new \$2,500,000 University Hospital, Iowa City.

**Mason City Hospitals Merge.**—Park and St. Luke's Hospitals, Mason City, have merged and patients from the latter institution are being moved to Park hospital until the St. Luke's new building is completed.

**Work Begun on New Hospital at Clarinda.**—A hydrotherapeutic building is being planned at the Clarinda State Hospital, Clarinda, at a cost of \$125,000. Excavation has begun and it is expected that the building proper will be completed early in 1925.

**Broadlawns to Have New Addition.**—The Broadlawns Hospital (Polk County Public Hospital), Des Moines, is planning a forty-bed addition to the present plant. Mr. T. B. Kidner, institutional advisor, National Tuberculosis Association, is consultant in charge of the building program.

#### Kansas

**Christ Hospital to Have New Home.**—Bids are being taken for the erection of a new home for Christ Hospital, Topeka, to have 100 beds.

**Plan Hospital for Clay Center.**—A tax levy has been ordered and a site provided for the erection of a \$50,000 hospital building at Clay Center.

#### Kentucky

**New Home for Waverly Hills Sanitarium.**—Plans are being made for the erection of a new \$1,000,000 home for the Waverly Hills Sanitarium, Valley Station.

#### Maine

**Campaign for Hospital for Rumford.**—An organization has been formed in Rumford to carry out a campaign to raise \$200,000 for the founding of a new hospital to serve that town and the towns of northern Oxford.





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**Eudowood Sanatorium to Be Enlarged.**—Ground will be broken soon for the erection of a new hospital and administration building for Eudowood Sanatorium, Townson. The building will be a three-story structure with twelve private rooms besides operating rooms and offices to be completed in about six months.

**Purchase Site for New Sanatorium.**—The state has purchased Mount Wilson, near Pikesville, from the Thomas Wilson Sanitarium. The hospital tract comprises 210 acres and only slight changes will be made to equip it as a new state tuberculosis sanatorium. The trustees of the fund left by the late Thomas Wilson for the treatment of children feel that they can now best administer the fund by withdrawing it from the hospital and devoting it largely to preventive work among children. The \$500,000 income is being devoted to maintaining a babies' ward at Union Memorial Hospital, in conducting the Happy Hills Convalescent Home, welfare stations in Highlandtown and at Curtis Bay, and in contributions to the Babies' Milk Fund.

**Massachusetts**

**New Home for Marlboro Hospital.**—The Marlboro Hospital, Marlboro, is building a new forty-four bed home.

**To Survey Springfield Hospital.**—The trustees of the Springfield Hospital, Springfield, and Mr. John C. Gardiner, superintendent, have engaged Dr. S. S. Goldwater, New York, N. Y., to make a survey of the present hospital plant with a view toward its future development.

**Michigan**

**Nurses' Home for Christian Psychopathic Hospital.**—Work has begun on the new \$25,000 nurses' home at the Christian Psychopathic Hospital, Cutlerville.

**Union Memorial Clinic Nears Completion.**—The Union Memorial Clinic, Grand Rapids, will be completed soon, according to a recent announcement. The building is five stories high.

**Addition to the Grace Hospital.**—The Grace Hospital, Detroit, has under construction a new employees' dining room and serving rooms which are expected to be completed this fall.

**St. Mary's Hospital to Have New Home.**—A six-story building is soon to be erected in Saginaw as the new home for Saint Mary's Hospital. The new home will contain eighty-five private rooms and will cost \$50,000.

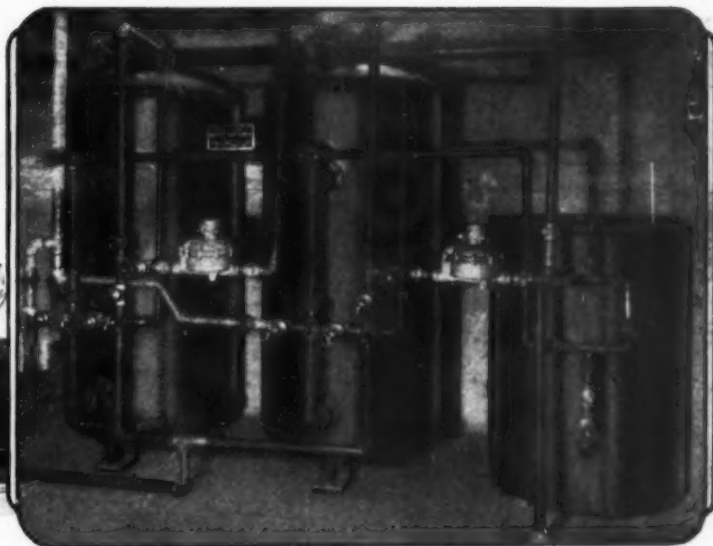
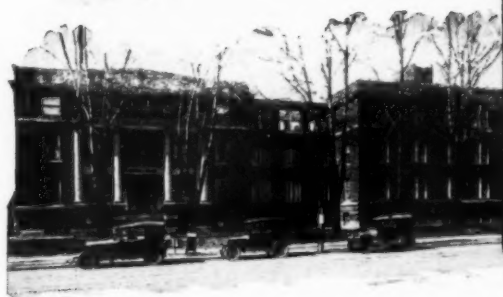
**Dr. Munson Resigns.**—Dr. James D. Munson has retired from the superintendency of the Traverse City Hospital, Traverse. Dr. Munson is seventy-five years of age and has spent forty-five of those years in the service of Michigan state hospitals.

**Dr. Barrett Made Consultant of Veterans' Bureau.**—Dr. Albert M. Barrett, medical director of the State Psychopathic Hospital, Ionia, Mich., has been appointed a member of the board of medical consultants of the U. S. Veterans' Bureau, Washington, D. C.

**Dr. Greene to Owosso.**—Dr. I. W. Greene, former chief of the medical out-patient department, University Hospital, Ann Arbor, has located at Owosso, where he will be director of the medical laboratories of the Owosso Memorial Hospital and where he will practice internal medicine.

**Lay Cornerstone of New Butterworth Hospital.**—The cornerstone of the new Butterworth Hospital, Grand Rapids, was laid July 23. Mr. Edward Lowe, president of the board of trustees, who contributed the site and \$500,000 toward the erection of the hospital, laid the cornerstone.





At the top of this page is the Flower Hospital of Toledo. At the right the Passavant Hospital of Pittsburgh, and above the Boone County Hospital, Iowa. All equipped with Paige-Jones Zeolite Softeners.

## Paige-Jones Deliver Unusual Soft Water Service

More and more hospitals and institutions are installing Paige-Jones Zeolite Softeners to insure a dependable soft water supply with the utmost economy and ease of operation.

Soft water means a decided saving in general operating costs as a result of keeping boilers, heaters, pipe lines, sterilizers and other equipment free from scale. In the laundry, soft water means less soap and other supplies and an improved quality of work.

With the exclusive upward flow method of operation of the Paige-Jones Softeners all the advantages of soft water actually cost less than hard water.

The upward flow principle means greater capacity for the same size softener unit, less salt for regeneration, and high rates of flow with very small pressure loss.

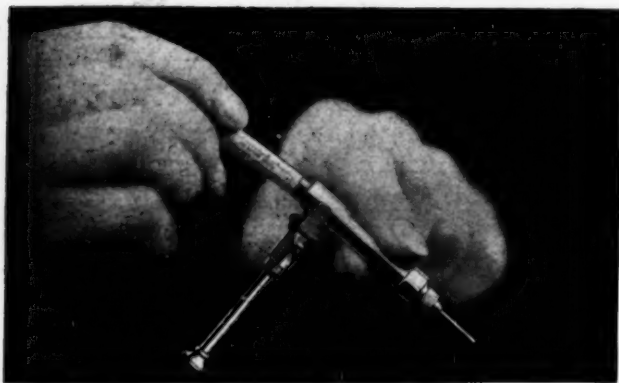
Operation of these softeners requires very little attention and is extremely simple. Regeneration of the softener takes from 18 to 30 minutes, total, and there is no need of backwashing before regeneration.

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You save ten minutes each time you administer a hypodermic with a "Cook Syringe."

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The "CARPULE"—a hermetically sealed glass cartridge-ampule—containing the medication, is loaded into the syringe.

The needle end of the "CARPULE" is immediately pierced by the inner end of the double pointed needle; the rubber stopper at the opposite end of the "CARPULE" is moved forward as pressure is applied to syringe piston, expelling the medication through the needle.

Wastage is entirely eliminated because the rubber diaphragm in the needle end of the "CARPULE" is automatically sealed when "CARPULE" is removed from syringe, making it possible to safely retain any unused portion for future use.

Cook "CARPULE" Service is a distinct economy, saving time and material; it also saves the annoyance and expense of spillage and breakage.

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Write for information and prices.

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**Carpule**

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**Plan New State Hospital.**—The state administration board is planning for the possible erection of at least one new hospital for the insane in the southern part of the state, and for the enlargement of hospitals for the insane at Kalamazoo, Traverse City, and Newberry. Funds are now available for the construction of a new hospital, and the board is making its study with a view of presenting the results to the legislature next winter.

### Minnesota

**Trachoma Hospital for Eveleth.**—A site has been purchased and provision made for the proposed new Trachoma hospital for Eveleth.

**New Wing for Ancker Memorial Hospital.**—A new wing for contagious diseases is being planned for the Ancker Memorial Hospital, St. Paul.

**Winona Hospital to Have Tuberculosis Ward.**—The Winona Hospital, Winona, is to have a tuberculosis ward made possible through the bequest of Dr. H. F. McGaughy, Winona, who donated the sum of \$34,000 with the intention of establishing a tuberculosis hospital.

**Australians Invited to Visit Mayo Clinic.**—Prof. John Hunter and Dr. N. D. Royle, Sidney, Australia, will visit the Mayo Clinic in October and will exhibit the technic of their operation for spastic paralysis. The invitation has been extended by Drs. William J. Mayo and Franklin H. Martin, director general, American College of Surgeons.

**Miss Powell Resigns to Accept Western Reserve Post.**—Miss Louise M. Powell has resigned as director of the school of nursing, University of Minnesota, St. Paul, to accept a similar position at Western Reserve University, made vacant by the resignation of Miss Carolyn E. Gray. Miss Powell's successor at the University of Minnesota will be Miss Marian L. Vannier, Elliot Memorial Hospital, Minneapolis.

### Missouri

**Annex for Freeman Methodist Hospital.**—An annex to the Freeman Methodist Episcopal Hospital, Joplin, is being built.

**New Arcadia Valley Hospital, Ironton.**—Work is progressing on the new Arcadia Valley Hospital, which is expected to be completed by spring, 1925.

**Elected President of Springfield Hospital.**—Dr. Samuel F. Freeman, Springfield, has been elected president of the Springfield Baptist Hospital, Springfield.

**Dr. Smith to Superintend Missouri Pacific Hospital.**—Dr. Wells F. Smith, formerly of Springfield, will take charge of the new \$750,000 Missouri Pacific Railway Hospital which is being erected at Little Rock.

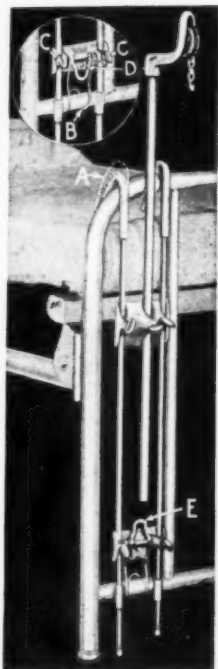
**Dr. Hctor to Superintendent State Hospital.**—Dr. Emmett F. Hctor, Nevada, has been appointed superintendent, State Hospital No. 3, Nevada, to succeed Dr. R. C. Robertson, acting superintendent. Dr. Hctor has been assistant physician at the state hospital since November, 1923.

### Nebraska

**Good Samaritan Hospital Opens.**—Dedication exercises for the new Good Samaritan Hospital, Kearney, were held July 23. In addition to the hospital building proper, a heating plant, laundry and home for the Franciscan sisters in charge, comprise the institution.

### New Jersey

**New Jersey State Hospital to Enlarge.**—Plans have



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July 3rd., 1924.

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823 New Nelson Building,  
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We take pleasure in highly recommending their use to hospitals, and surgeons in general.

We also wish to express our sincere appreciation for the kind and courteous services shown by your representative Mr. L. J. Schultz.

Wishing your firm continued success, in the humane method of treating fractures, we are,

Very truly yours,

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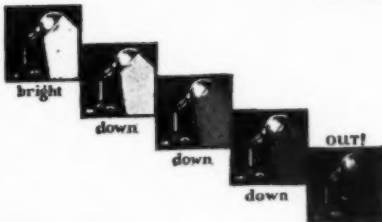
Many hospitals now use DIM-A-LITE in all rooms. It can be turned up or down, like gas.

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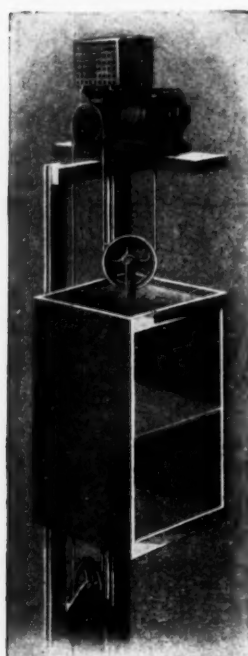
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75 lbs. 100 F.P.M.	120-220	25-60 cy-
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Hospitals  
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Pages 2186-2187

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been completed for a new group of buildings for the New Jersey State Hospital, Morris Plains.

**New Jersey T. B. Sanatorium to Be Enlarged.**—Plans are being drawn for a new fourteen-bed addition to the New Jersey Sanatorium for Tuberculosis Diseases, Glen Gardner.

**New Camden County Tuberculosis Hospital.**—Work is now under way for the new Camden County Tuberculosis Hospital, Asyla, which will be erected at a cost of \$1,250,000.

**West Hudson Hospital to Have New Home.**—Plans have been approved for the new home for the West Hudson Hospital, Kearney. It is to be a three-story building to contain eighty beds.

**Mountainside Hospital Nears Completion.**—Announcement has been made to the effect that the new seventy-two bed addition to the Mountainside Hospital, Montclair, will be completed by October 1.

**New Nurses' Home for Nathan and Miriam Barnett Memorial Hospital.**—The cornerstone was recently laid for the new nurses home for Nathan and Miriam Barnett Memorial Hospital, Paterson. It will be a forty-bed home to be erected at a cost of \$160,000.

**Lay Cornerstone of Somerset Hospital.**—The cornerstone for the new Somerset Hospital, Somerville, was laid July 21. The new hospital which is being built by the citizens of Somerset and Hunterdon counties, will be a three-story building of brick and Indiana limestone, containing fifteen private rooms, twenty-one semi-private beds and thirty-two ward beds.

## New York

**Jamaica Hospital Opens.**—The new Jamaica Hospital was opened for public inspection August 15.

**New Home for Medina Hospital.**—A new two-story building is being erected for the Medina Hospital, Medina.

**Nyack Hospital to Have New Home.**—A new seventy-bed home is being erected for the Nyack Hospital, Nyack.

**Valhalla to Have Convalescent Home for Boys.**—Plans are being prepared for a fifty-bed convalescent home for boys, Valhalla.

**Hospital for State Industrial School.**—A two-story hospital is in the process of erection at the State Agricultural and Industrial School, Industry.

**Emergency Hospital to Enlarge.**—The erection of an additional story for the Emergency Hospital of the Sisters of Charity, Buffalo, is being planned.

**New Brooklyn Hospital.**—The foundation has been laid and work is progressing on a new seven-story hospital with a bed capacity of 200, for Brooklyn.

**Nurses' Home for Beth Moses Hospital.**—A new nurses' home is being planned for Beth Moses Hospital, as well as an addition to the present hospital.

**Plan Sudenham Post-Graduate Hospital.**—Plans for the erection of the new Sydenham Post-Graduate Hospital on the west side of Manhattan have been completed and the contract awarded.

**New Wing for Mount Vernon Hospital.**—Excavation work is under way for the new wing of Mount Vernon Hospital, Mount Vernon. It will be a four-story building to contain 152 beds.

**Addition to St. Mark's Hospital.**—St. Mark's Hospital, New York, is to be rebuilt, but in such a manner as not to interfere with its present clinical activities. The buildings, when completed, will cost \$1,250,000.

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are entirely waterproof—free from cardboard and glue. A waterproof surface layer—an integral part of the screens—makes it easy to keep them clean and dust-free by washing.

Eastman screens are fast, free from lag—have minimum grain and maximum definition. And—

The quality is uniform from screen to screen.

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the Research Laboratories of the

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No word better illustrates the first essential of successful hospital campaigns.

Experience, training, natural fitness for the work are mighty factors but they are secondary to the greater ability that *adapts* an organization to the needs and particular conditions of a community.

MARY FRANCES KERN'S thorough familiarity with hospital problems generally, because of her experience as hospital superintendent, plus her phenomenally successful record in fund-raising campaigns fits her peculiarly for this work. If you contemplate a campaign it is only good judgment to obtain her counsel and advice.

We use no cut and dried system. Our system is builded around the results of a survey which takes into careful consideration the special needs or out-of-the-ordinary conditions peculiar to the community.

We do not sacrifice the drive to any set plan or system.

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**Enlarge Bellevue Nurses' Home.**—Dr. John J. McGrath, president, Bellevue and Allied Hospitals, New York, has announced that an additional wing, which will accommodate 125 nurses, will be added to the nurses' home at Bellevue.

**Dr. Fleming Transferred to Harlem Hospital.**—Dr. Mark L. Fleming, assistant general superintendent, Bellevue Hospital, has been transferred to the superintendency of the Harlem Hospital. Dr. John J. Hill will succeed Dr. Fleming at Bellevue Hospital.

**New Addition for Binghampton City Hospital.**—The Binghampton City Hospital, Binghampton, is planning an addition. One of the buildings will be used for a kitchen, dining room and operating room, and the others for the housing of contagious disease patients.

**Broad Street Hospital Purchases Four-Story Building.**—The Broad Street Hospital, located northeast corner of Broad and State streets, has purchased from the church of St. Stanislaus the four-story building adjoining its present holdings. The hospital now controls a frontage of 192.4 feet on Broad Street.

**Plan Wing for Wyckoff Heights Hospital.**—Plans have been prepared for an addition to the Wyckoff Heights Hospital to be erected on a vacant lot at the Stockholm street corner of the institution and a campaign to raise \$350,000 for this purpose is under way. The new wing will be five stories high and will provide accommodations for private patients.

**Plan New Jewish Maternity Hospital.**—The Jewish Maternity Hospital proposes to erect a new hospital to accommodate 150 patients on its recently acquired site at Fifth avenue and 108th street, New York, N. Y., and has engaged Dr. S. S. Goldwater, director, Mount Sinai Hospital, to supervise the planning of the new building, which will cover a corner plot 75 by 125 feet and will probably be ten stories high.

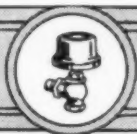
**Plans for New Buildings and Additions to New York Hospitals.**—Buildings and additions for the following hospitals have been approved: Kingsland Avenue Children's Home, Bronx, construction of a three unit, two-story fire-proof structure; Brooklyn Nursery and Infants' Hospital, fire-proof porch and fire escapes; Brooklyn Home for Children, alterations and improvements; Town of Hempstead Home for the Aged, hospital building; Berkshire Industrial Farm, Canaan, construction of new dormitory; cottage to be known as the Edwin Gould, Jr., Cottage; Miamonides Lodge Hospital Association, Liberty, alterations and additions to building for hospital purposes; House of the Good Shepherd, Utica, alterations in stairways; Binghampton City Hospital, erection of three additional pavilions; Leake and Watts Orphan house, Yonkers, erection of a two-story and basement fireproof cottage; Lakeview Home, Arrochar, small addition; Hudson City Hospital, three-story fireproof brick buildings, five stories high, primarily for accommodation of private patients; Oswego Hospital, remodeling and additions to main building; Asylum of Our Lady of Refuge, Buffalo, building for the care of younger girls.

### North Carolina

**Dr. Scott Opens New Hospital.**—The new Scott Hospital, Sanford, opened in the middle of July.

**Guilford Tuberculous Sanatorium to Enlarge.**—Work has begun on a new twelve-bed addition for colored patients, Guilford Sanatorium, Greensboro.





# The Ford Hospital

Detroit

This mammoth, modern institution is completely equipped with The Johnson System of Temperature Control. The Johnson System is relieving attendants of turning on and off the radiator valves and preventing dangers of possible mishandling, guess-work and neglect. At the same time, it is strictly maintaining the exact temperature and ventilation each room severely requires, avoiding any possibility of temperatures being wrong, and drafts existing. And all the while The Johnson System is holding this hospital's fuel consumption far below the excess and waste that would prevail without it. Indeed, no hospital is today fully efficient unless equipped with The Johnson System of Temperature Control.

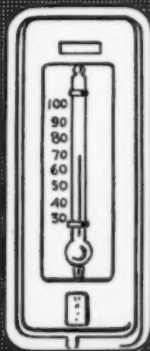
*This company, in business thirty-nine years and all of that time devoted exclusively and entirely to automatic temperature and humidity control, has established its permanency and reliability, as well as the reliability of its apparatus.*

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The calories, proteins and minerals which make oats one of the most valuable of all cereal foods are offered in the form of a dainty. When you urge mothers to serve oats, tell them to be sure these oats are Quaker.

Quaker Oats are flaked from the finest grain grown—from big, plump kernels selected for super-quality. We get only about 10 pounds to a bushel. That's why culinary experts always say Quaker when they order oats.

**Standard full size and weight packages—**

Medium: 1½ pounds

Large: 3 pounds, 7 oz.

**Quick  
Quaker**

*Cooks in 3 to 5  
minutes*



**Quaker  
Oats**

*The kind you have  
always known*

**Watts Hospital Plans Expansion.**—The board of trustees of the Watts Hospital, Durham, is planning on erecting a wing to the present institution, but the definite building program has not yet been definitely formulated.

**Lincoln Hospital Nears Completion.**—Announcement has come that the new Lincoln Hospital, Durham, is nearing completion and will be ready for occupancy September 1. The new home is to contain thirty-eight beds.

#### Ohio

**New Lorain County Hospital.**—A new two-story \$500,000 hospital is being planned for Lorain County, Crofton.

**Bethesda Hospital Addition Opens.**—The new addition to the Bethesda Hospital, Zanesville, which brings the capacity of the hospital up to 200 beds, has just been completed.

**To Be Financial Secretary of Flower Hospital.**—The Rev. George H. Smith, formerly pastor of Broadway Methodist Episcopal Church, Toledo, is the new financial secretary of Flower Hospital, Toledo.

**To Superintend Nurses at White Cross Hospital.**—Miss Jessie Harrod has become superintendent of nurses at White Cross Hospital, Columbus, succeeding Miss Elizabeth Reynolds, resigned. Miss Harrod has been connected with a Rochester, N. Y. hospital.

**Plan Homeopathic School in Connection with Hospital.**—A definite program is now on way for a national school of homeopathy in Cleveland in conjunction with the new Homeopathic Hospital to be built on the Forest Hill Estate of John D. Rockefeller, according to the announcement of Dr. Lester E. Siemon, president, American Institute of Homeopathy.

**Approve Budget for District Tuberculosis Hospital.**—A budget of \$45,000 for the district tuberculosis hospital, operated by Clark, Green, Madison, and Champaign counties has been approved. Under an arrangement whereby the cost of each county is apportioned in ratio to the number of patients received, Clark county will bear 85 per cent of the cost.

**Emergency Tuberculous Hospital Closes.**—The emergency tuberculosis hospital maintained by Stark County for the last two years, was closed July 15. Patients will be sent to other institutions until the county's new sanitarium is erected. The hospital was closed, as the number of advanced cases to the care of which the hospital was principally devoted were greatly reduced.

**Cornerstones Laid for Two Cleveland Hospitals.**—The cornerstones of the Babies' Hospital and the new Maternity Hospital, Cleveland, two hospitals which are to be in the Western Reserve University-Lakeside hospital group were laid June 20. The two buildings, to cost \$3,300,000 will be completed next year.

**Contracts Let for New Allen Hospital.**—Contracts for the new Allen Hospital, Oberlin University, Oberlin, were let in July and it is hoped that the building will be ready for occupancy next February. The hospital was first planned in 1915 when a gift for \$50,000 in the name of Dr. Dudley P. Allen was announced. A recent campaign for funds brought an anonymous pledge for another \$50,000 and miscellaneous small gifts. The hospital is to be one-story containing twenty-eight beds.

**Gift to St. Luke's Hospital.**—A gift of \$2,000,000 was recently made to St. Luke's Hospital, Cleveland, by Mrs. F. F. Prentiss, as a memorial to Dr. Dudley P. Allen. The gift was made with the provision that \$1,000,000 be



*In this delivery room, sound is localized by the Johns-Manville Acoustical Treatment.*

# Quiet

## —at the Lawrence Hospital

**T**HE value of quiet as an aid to the recovery of patients and the efficiency of its personnel is recognized at the Lawrence Hospital, Bronxville, N. Y.

Johns-Manville Acoustical Treatment in corridors and noisy rooms localizes unavoidable noises and prevents their transmission throughout the building.

This treatment succeeds where "Silence" signs fail, and greatly increases the comfort of hospital buildings. Let us show you what can be done with it. You incur no obligation.

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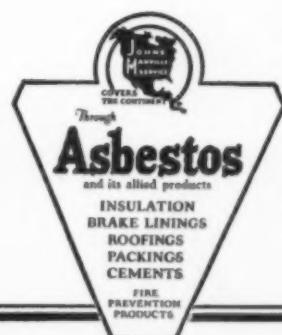
For Canada: CANADIAN JOHNS-MANVILLE CO., Ltd., Toronto



*Johns-Manville Acoustical Treatment in this corridor retards the transmission of sound through the building.*

# JOHNS-MANVILLE

## Acoustical Correction





# Books for Nurses

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used for building purposes and the second as an endowment fund, the whole to be contingent on the raising of an additional million by public subscription. A campaign was conducted in northern Pennsylvania, northeastern Ohio and western New York to raise the third million.

A sixteen acre site has been acquired for the new St. Luke's hospital which will, in the beginning, have accommodations for 250 beds, a nurses' home, power and heating plants, and other essential auxiliaries.

### Oklahoma

**Hospital for Cherokee Orphans' Training School.**—Construction of the new \$10,000 hospital at the Cherokee Orphans' training school, Tahlequah, is to be started soon, according to the announcement of H. C. Calhoun, supervisor of the Indian schools.

### Oregon

**New Addition to Emanuel Hospital.**—Plans are being prepared for a new addition to Emanuel Hospital, Portland.

**Addition to Keiser Brothers Hospital.**—An addition to contain forty beds is to be erected at Keiser Brothers Hospital, North Bend.

### Pennsylvania

**New Hospital for Charleroi.**—A new hospital to contain 100 rooms is being planned for Charleroi.

**New Children's Home Dedicated.**—The new St. Joseph's Orphan Asylum Hospital, Erie, was recently dedicated.

**New Pavilion for Bellefonte Hospital.**—Plans have been completed for a new pavilion for Bellefont Hospital, Bellefonte.

**St. Joseph's Hospital to Enlarge.**—A new fifty-eight bed addition is being planned for the St. Joseph's Hospital, Reading.

**New Home for Conemaugh Memorial Hospital.**—A new 300 bed home is to be erected at the Conemaugh Memorial Hospital, Johnstown.

**Plan Children's Hospital of Pittsburgh.**—Announcement has come that ground for the new home for the Children's Hospital, Pittsburgh, will be broken this fall.

**Chester County Hospital to Have New Home.**—A new home is being erected for Chester County Hospital, West Chester. The building is to contain 115 beds and will cost \$100,600.

**Nurses' Home for West Side Hospital.**—The cornerstone of the new nurses' home for the West Side Hospital, Scranton, was laid recently. The new home is to be a two-story building.

**Gynecean Hospital Closed.**—The Gynecean Hospital, Philadelphia, which has been operating for the past thirty-seven years, as an adjunct to the morals court, has ceased functioning.

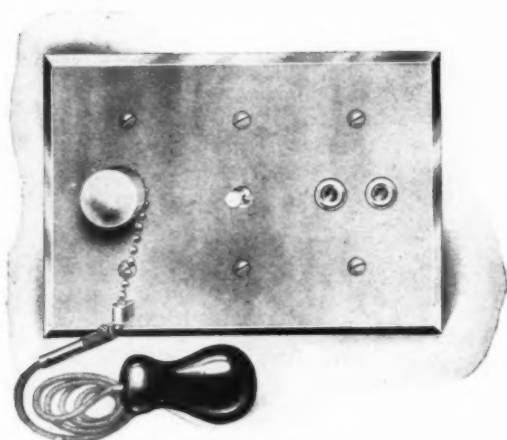
**Justice Frazer Elected Hospital Head.**—Justice Robert S. Frazer, state supreme court, was elected president, Elizabeth Steele Magee Hospital, Pittsburgh, to succeed the late Senator William Flinn.

**New Addition to Homeopathic Hospital.**—The new addition planned for the Homeopathic Medical and Surgical Hospital and Dispensary, Pittsburgh, is to include a 125-bed pavilion and a complete new maternity unit.

**Wyoming Valley Hospital to Enlarge.**—Plans have been

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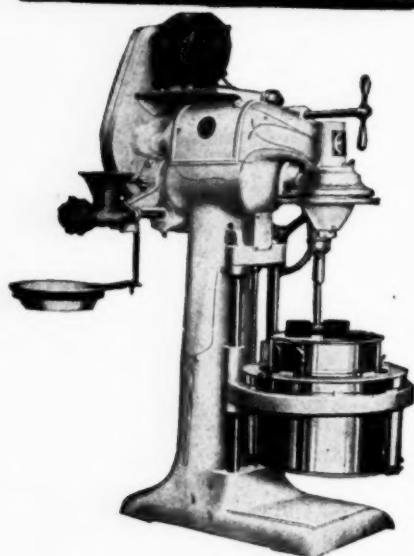
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completed for a new addition to the Wyoming Valley Homeopathic Hospital, Wilkes-Barre. The building will contain a kitchen, nurses' dining room, and several new wards.

**Dr. Turnbull to Head Palmer Memorial Hospital.**—Dr. William G. Turnbull, deputy secretary of health, has accepted a position as head of the Palmer Memorial Hospital which will be erected on the west side of the Hudson river, near Kingston, N. Y.

**Survey of Memorial Hospital of Philadelphia.**—The board of managers of the Memorial Hospital of Philadelphia, Roxborough, have requested Dr. S. S. Goldwarer, New York, N. Y., to collaborate with Mr. William F. McBride, superintendent of the hospital, in a survey and report of the immediate needs of the hospital and its future growth, with particular reference to the erection, in the near future, of a maternity department.

## Rhode Island

**New Home for Providence Lying-in Hospital.**—Plans are being prepared for the new home for the Providence Lying-in Hospital, Providence.

**New Hospital for Wakefield.**—South County is to have a new hospital at Wakefield which is to be three stories high and contain twenty-three beds with emergency space for fourteen more.

## South Carolina

**To Direct Waverly Sanitarium.**—Dr. C. R. F. Beall, formerly of Mayesville, has assumed the post of medical director, Waverly Sanitarium, for mental and nervous diseases, Columbia. The sanitarium has recently opened a hydrotherapy and physiotherapy department.

**New Addition to Sanders Memorial Hospital.**—A new three-story addition is being built for Sanders Memorial Hospital, Florence.

**New Administration Building for Orangeburg.**—A new three-story administration building is to be erected at the Orangeburg Hospital, Orangeburg.

**Spartanburg Has New Nurses' Home.**—The new nurses' home of the Spartanburg Hospital, Spartanburg, will soon be completed. The home will accommodate forty-five nurses.

## South Dakota

**Dr. Fonkalsrud to Sioux Falls.**—Dr. A. O. Fonkalsrud has moved from Minot, N. D., to Sioux Falls, to take up the work of the Bethany Hospital Association of the Lutheran Church.

**American Legion Sanatorium Dedicated.**—The tuberculosis sanatorium building erected at a cost of \$40,000 by the American Legion Auxiliary for South Dakota ex-service men at Sanator, near Custer, was dedicated August 1. The building contains twenty-four bedrooms with two beds in a room and a sleeping porch for each room. The sanatorium has been named the Moodie Memorial in recognition of the services of Mrs. Mable Moodie, Elk Point, who had charge of raising the funds and erecting the buildings.

## Tennessee

**Civic League Hospital Superintendent Resigns.**—Miss L. Anderson, superintendent, Civic League Hospital, Jackson, has resigned her position which will temporarily be filled by Miss Lillian Pentecost who will be acting superintendent.

**La Follette Has Two-Day Emergency Hospital.**—The community club house, La Follette, was converted into an





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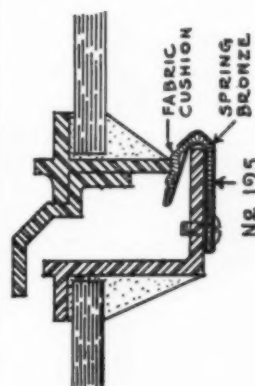
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emergency hospital, July 30, and 31 when a public health clinic was held. The reading rooms were used as operating rooms and the auditorium served as a large ward.

**Miss Van Wort to Reorganize Knoxville General Hospital.**—Miss Rosa Van Wort assumed her new duties as superintendent of the Knoxville General Hospital and nurses' training school, Knoxville, July 15. Miss Van Wort has had fifteen years' experience in hospital work during which time she has served at Johns Hopkins, Baltimore, Md., and reorganized Stuart Circle Hospital and St. Elizabeth and Memorial Hospitals, Richmond. She will reorganize Knoxville General Hospital by the addition of several special wards and clinics, and will train a staff to operate the hospital after she completes her work, which she expects will require about six months.

## Texas

**Children's Addition for Santa Rosa Infirmary.**—A new children's addition to contain 125 beds is being planned for the Santa Rosa Infirmary, San Antonio.

## Virginia

**First Unit of Virginia Baptist Hospital Opened.**—The first of the four units of the Virginia Baptist Hospital, Lynchburg, was formally opened July 10. Though owned by the Baptist denomination, the hospital is to be non-denominational.

## West Virginia

**Hospital for Kenova.**—A hospital owned by Dr. Jay W. Rife, Kenova, and Dr. Jack W. Ferguson, Westmoreland, which will open early in August, will be the first hospital to be established in Kenova.

## Wisconsin

**New Wing for Southview Municipal Hospital.**—The Southview Municipal Hospital, Milwaukee, is planning the erection of a new \$18,000 wing.

**New Addition for St. Nicholas' Hospital.**—A new addition is being erected for St. Nicholas' Hospital, Sheboygan, which will increase the bed capacity to 300.

**Nurses' Home for State of Wisconsin General Hospital.**—Plans have been completed for the erection of a ninety-six bed nurses' home for the State of Wisconsin General Hospital, Madison.

**Franciscan Sisters Take Over Marquette Hospital.**—The Marquette Hospital, Milwaukee, was taken over, August 1, by the Franciscan Sisters whose mother house is at Little Falls, Minn.

## Wyoming

**Plan State Tuberculosis Sanatorium.**—A new tuberculosis sanatorium is to be built sometime during 1925 at Cheyenne, according to the announcement of the State Board of Charities and Reforms. The exact site has not yet been selected.

## Canada

**New Unit of Provincial Mental Hospital Opened.**—The new unit of the Provincial Mental Hospital, Essondale, B. C., erected at a cost of \$1,000,000, was recently opened. Dr. Harold C. Steeges is superintendent of the hospital.

**Plan Addition to Oshawa General Hospital.**—A new addition is being planned for the Oshawa General Hospital, Oshawa, Ont., to provide for the mechanical roentgen ray and laboratory departments which, at present, are scattered throughout the buildings.

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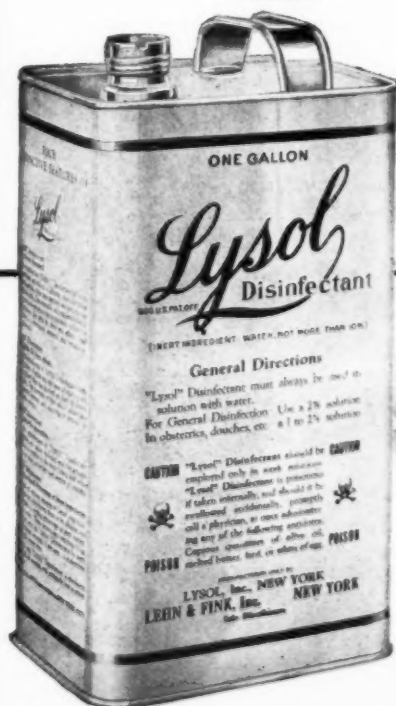
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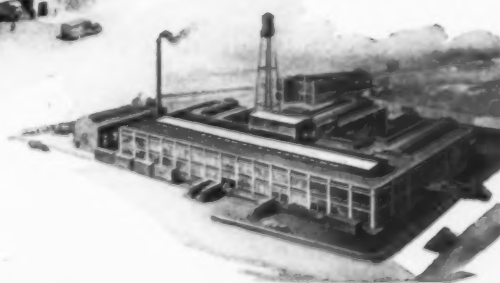
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## Trade News and Publications

**Crooks Veneered Doors.**—Catalogue No. 16 describing and illustrating Crooks hardwood veneered doors and panels has recently been issued by W. D. Crooks & Sons, Williamsport, Pa.

**Kitchen and Dining Room Supplies.**—A new complete catalogue of kitchen and dining room supplies has just been received from the Ford Hotel Supply Co., St. Louis, Mo., manufacturers of hotel and other institutional kitchen and dining room equipment.

**Arktite Circuit-breaking Plugs and Receptacles.**—The Crouse-Hinds Company, Syracuse, N. Y., has issued its bulletin No. 2055, describing and illustrating the Arktite circuit-breaking plugs and receptacles.

**Mallinckrodt Chemicals Price List.**—The June, 1924, price list of the Mallinckrodt Chemical Works, New York, N. Y., has just been received.

**Kny-Scheerer Service Bulletin.**—The July, 1924, bulletin, "Service," has come from the Kny-Scheerer Corporation of America, extensive manufacturers of hospital and surgical equipment.

**Super-Kasters for Hospital Furniture.**—The Steidle Manufacturing Company, Cincinnati, Ohio, has issued a folder illustrating its super-kasters and enumerating the twelve reasons why these casters have proved superior in hospital use.

**Dix-Make Uniforms.**—A booklet describing the Dix-make uniforms for women has come from Henry A. Dix & Sons Corporation, New York, N. Y. The different makes of uniforms for nurses and other institutional workers are pictured and described in detail.

**Raisin Recipes for Hospitals and Sanitariums.**—Mrs. Belle DeGraf, domestic science department, Sun-Maid Raisin Growers Association, Fresno, Cal., has compiled a booklet of raisin recipes for hospitals and sanitariums. The booklet is divided into two series, one of which contains the quantities for ten patients and the other quantities for one patient.

**Booklet on Plaster of Paris Bandages.**—A booklet on Plaster of Paris bandages has just been published by Johnson & Johnson, New Brunswick, New Jersey, describing the manufacture and preparation of these bandages. One chapter contains an article by a professor of orthopedic surgery, Jefferson Medical College, Philadelphia, on "How Long Should a Plaster of Paris Dressing be Allowed to Remain Upon a Patient." Another article deals with methods for retarding or speeding up the setting time.

**Dumore Drink Mixer.**—The Horlick's Malted Milk Company, Racine, Wis., has distributed a folder describing the new electric mixer No. 6 for preparing barium sulphate and Horlick's malted milk. The new mixer is designed for the use of roentgenologists as a medium of suspension in diagnosis.